HISTORY OF THE DEPARTMENT OF PEDIATRICS

University of Alberta 1919-1992

collated by W C Taylor & H B Armstrong

HISTORY OF THE DEPARTMENT OF PEDIATRICS
UNIVERSITY OF ALBERTA 1919-1992

A History of the Department of Pediatrics at the University of Alberta, 1919–1991

Collated by

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DEDICATION

In the last few decades Pediatrics at the University of Alberta has grown from a Division of the Department of Medicine to independent departmental status with a complete range of subspecialities. This growth has coincided with the full flowering of scientific pediatrics. Incredible advances in molecular biology have brought us to the threshold of gene therapy for many major diseases, a concept that was science fiction only a short while ago. Nineteen-ninety-three will bring a major reorganisation of Pediatrics in the City of Edmonton which will result in further improvements in health care for the children of Northern Alberta. During this time the qualities of caring, compassion, and concern for children have been fostered and passed on to graduates of our medical school and pediatric graduate training program by many exceptional faculty members. Amongst these, there was one whose special qualities inspired us all.

This brief history of the Department is dedicated to Brock Armstrong who was born in the same year as the Department was founded

Dr. Brock Armstrong

and died in 1992. He will be remembered for many things but we in the Department treasure his life as a Pediatrician. Brock was first and foremost a children's doctor who revelled in his avocation and maintained that enthusiasm until his death. While not an academic in the narrow definition of the word, Brock excelled as a clinical teacher and an exemplar to both students and colleagues. With patients his aura of gentle competence reassured and. rapidly gained their confidence. All his actions bespoke his deep concern for and his love of children. No wonder that he was admired and respected by those of us who would aspire to the same high standards. Brock was always conscious that future achivements are built upon those of the past and was acutely aware that history should be preserved. In his retirement he devoted a great deal of energy developing the Department archives, and with Bill Taylor conceived the idea of a history of the the Department to the present time. The outcome is this volume, a fitting memorial to one who throughout his long career, gave full measure to the cause of children's health.

PREFACE

The Department of Pediatrics at the University of Alberta had its origins in the early 1920s as a tiny offshoot, a newly created division, of the Department of Internal Medicine, when Dr. Douglas Leitch was appointed to give a few lectures on the subject. The first full-time professor and head of the Division was not appointed until 1956, when Dr. Kenneth Martin arrived from Winnipeg. Since then, progress has been at an ever-accelerating pace, and, in retrospect, has been so spectacular that members of the Department can justifiably feel proud of their achievements.

This history of our department was inspired by a set of comprehensive notes that Ken Martin had prepared for Tony Cashman, the official historian of the University of Alberta Hospitals. Ken very kindly presented us with a copy of the notes, to be used as we saw fit, and the occasion of Ernie McCoy's 'stepping-down' party seemed an appropriate moment when a first history of the Department should be unveiled. At that time, with the approval of Dr. Frances Harley we approached Ernie, and after some coaxing and arm-twisting he agreed to contribute a chapter covering his years as chairman. Henry Pabst and Adrian Jones checked the material for factual accuracy. Dr. Taylor contributed a chapter on his brief tenure as acting chairman (1968–69). In due course Drs. Harley and Olley wrote chapters concening their tenure of the Chair. And so this history of the Department of Pediatrics at the University of Alberta came to be compiled, and we started negotiations to have it produced.

We accept responsibility for the arrangement of the material but have tried to allow the authors to use their own words whenever we

felt they could bear repeating. As it was pointed out to the authors that they couldn't possibly include the name of everyone who had helped them over the past three decades, we are to blame if you find your name missing from these pages.

On behalf of all members of the Department we thank Daena McGuire, Trudy Stewart and Joanna Pocock for their help and dedication in typing and producing the history through several revisions of the script. Finally we are indebted to Ursula Mathews for her wonderful work in the final editing of the manuscript and the preparation of the material for publication.

William C. Taylor and H. Brock Armstrong.
June, 1992.

CHAPTER 1

PEDIATRICS IN ALBERTA: THE EARLY YEARS

DOUGLAS B. LEITCH, MC, MD, FRCPE, FRCPC.
Director of the Division of Pediatrics, Department of Medicine, University of Alberta, 1919–1956; and
Chairman, Department of Pediatrics, Royal Alexandra Hospital, 1923–1955

T.A. GANDER, MD, FAAP, FRCPC
Associate Clinical Professor, Department of Pediatrics, University of Alberta

On the occasion of the presentation of a painting of Dr. D.B. Leitch to the Royal Alexandra Hospital, Edmonton, on 13th December 1967.

Today, the Medical Staff of the Royal Alexandra Hospital are honoring Dr. Leitch, for the many contributions he has made to this hospital. In commissioning the painting of his portrait, we wished to express our sincere appreciation for these contributions.

Dr. Leitch has been a member of the Active Staff of this hospital for 45 years. He founded its Department of Pediatrics and was its chief for more than 30 years.

Dr. Douglas B. Leitch

On looking over his early medical career, it is not surprising that he should have achieved a place of honor and respect in his profession. He graduated from the University of Toronto in 1913 and undertook 4 years of training in pediatrics—this at a time when most medical students went into

practice direct from medical school. It is significant of his ability that he secured appointments for his postgraduate training in leading hospitals in Toronto and New York.

In his final year of training, Dr. Leitch decided that, as Canada was at war, he should be in the army. He paid his own fare to England to enlist with the Royal Army Medical Corps. Although he could have enlisted in Canada he felt this would take much longer, and if he was going to join he might as well go to where the action was! He got into action quickly enough—he was in France within 10 days of enlisting, joining the 32nd Welsh Division; he served as regimental officer in that Division throughout his time in action and was decorated with the Military Cross. The young officer's army career came to an end when he was wounded in action and evacuated to England.

While convalescing at a hospital in Bournemouth, Doug persuaded the matron to grant him 48 hours' unofficial leave. He used the time to go to Scotland, where he passed the exam for Fellowship of the Royal College of Physicians of Edinburgh—and made such an impression on the examiners that they asked him to assist with fellow candidates.

Upon discharge from the army because of his wound, Dr. Leitch returned to Canada. As luck would have it his father was in Edmonton—he was the minister at Highlands Methodist Church—and Dr. Leitch came straight to this city. He arrived in 1919 and has been in practice here since that time.

Ever since his arrival in Edmonton, Dr. Leitch has had a busy professional life. He established the Division of Pediatrics at the University of Alberta in 1919 and became its first Chief, serving in that capacity until the end of 1956. This position carried responsibility for arranging training in pediatrics for the medical students. In addition to planning the syllabus of training, for many years Dr. Leitch gave all the lectures and conducted the clinics

himself. He was instrumental in setting up the City of Edmonton's Well-Baby Clinics, and gave generously of his time in attendance at these clinics also. In addition, he served as president of the Edmonton Academy of Medicine for some years and as a member of the Edmonton Hospitals Board.

Dr. Leitch's greatest contribution, however, has been to the Royal Alexandra Hospital. He established the Department of Pediatrics here, in 1923, and was its chief from 1923 to 1955. When he took over, the pediatric ward was in the basement of what is now the Glenrose Hospital. He built up the Department until it occupied half of the top floor of the building as well as the isolation hospital next door, establishing a caliber of medical and nursing care of renown throughout Western Canada. It is significant that nurses in training were sent to the Royal Alexandra from city and rural hospitals for their pediatric training, and doctors in general practice came to train under Dr. Leitch to go on into the specialty of pediatrics.

Dr. Leitch has always been very popular throughout the medical profession. He is a friendly modest man, with a keen sense of humor, a ready smile, and a hearty laugh. He is able, in a few crisp sentences, to express the substance of any situation, whether this be medical or non-medical. In fact, there is one facet of medical practice in particular in which Dr. Leitch has no equal: in written consultations. His penmanship is beautiful, his choice of English perfect, he allows his sense of humor to come through, and his ability to summarize the entire problem and solution makes his report a masterpiece. If it were possible to make a collection of these consultation reports they would make a pediatrics classic.

Along with his other activities, Dr. Leitch engaged in full-time private practice, attending patients not only from the City of Edmonton but also from all over Northern Alberta. It seemed he was available 24 hours a day almost every day of the year, and for

many years there were few homes in Edmonton he had not visited to see sick children.

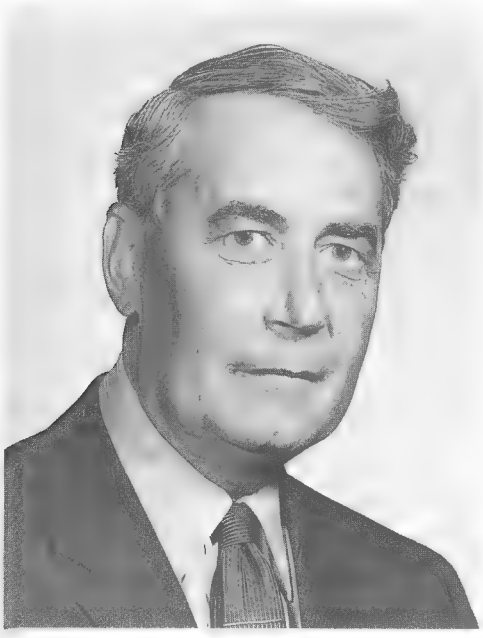
In honoring Dr. Leitch today, we would be remiss if we did not honor Mrs Leitch also. Nobody, not even Douglas Leitch, could have carried all the load alone, and to his wife goes a great deal of credit.

We have good reason to honor Dr. Douglas Leitch. The medical staff are very aware of the many contributions he has made, and we wish to assure him of our deep appreciation.

PROLOGUE

J. KENNETH MARTIN, MD, MRCP(Lond), FRCPC
Director of the Division of Pediatrics,
January 1957 to June 1968

Historically, it is interesting to look back over the past 50 years of pediatrics in Edmonton. In the early 1920s there were two pediatricians, Drs Leitch and Swallow. At the time I became head of Pediatrics, in January 1957, it was to take over from Dr. Leitch, who had held that position for 37 years. Both Dr. Leitch and Dr. Swallow had interesting anecdotes to relate of this period—for instance, I well remember the title of one such talk they gave, entitled Two Old Goats and the Kids! Jimmy Calder must have joined Dr. Leitch in the late 1920s, because at the time of his death, in 1970, he had been associated with the University for 40 years. Whereas Dr. Leitch's main affiliation had been at the Royal Alexandra, Jim Calder concentrated his work and teaching at the Camsell Hospital and Dr. Swallow's main affiliations were with the Royal Alex and University Hospitals.



Dr. J. K. Martin

In 1948, when I wrote from England to the Dean of Medicine at the University of Alberta

and Dr. E.P. Scarlett in Calgary (later, Chancellor of the University), enquiring about openings for a pediatrician, I was assured there was none in the foreseeable future. And in the early 1950s, when I passed through Edmonton while practising in Winnipeg, I enquired of Dr. Leitch; I was mainly interested in work involving teaching. However, although on this latter occasion I was plied generously with whisky and enjoyed to the full his superb humor and inimitable silent laughs, the impression I gained was negative.

Despite this early discouragement, in the summer of 1956 I was invited to attend interviews for the position of professor of pediatrics (the first full-time one) and head of the Department at the University of Alberta. I remember how attractive the campus looked at that time, with extensive lawns that set off the buildings, and lots of flower beds and well-established trees. Particularly attractive was the space in front of the old Arts Building, stretching from close to 87th Avenue to Saskatchewan Drive and facing onto 112th Street. In retrospect, this appearance marked the end of an era for the University of Alberta, which for 30 years or more had had a fairly steady undergraduate population of 3- to 5000. The rate of growth that would take place in the next 10 to 15 years, with the number of undergraduates tripling, was little anticipated. Buildings appeared in rapid succession in an assortment of architectural styles that radically changed the pastoral appearance of the campus.

I had the opportunity to see the Medical School and the University Hospital, where my work was to be centered, and I talked with the incumbent heads of departments, both clinical and preclinical. Of the former, only one was full-time—Donald R. Wilson, who was professor of medicine. Pediatrics had been a division of the Department of Medicine up to this time and did not include neonatology (the nurseries were the responsibility of the Department of Obstetrics). The pediatric segment of the interns' rotation consisted in 1 month on the children's wards of the various

hospitals, and there was no postgraduate training. Undergraduate teaching consisted of some ward rounds and a series of lectures in third and fourth year.

At that time, the curriculum here still placed heavy emphasis on class lectures, as had been common in many countries until after World War II. It is hard to imagine how the students managed to absorb anything from 6 to 8 hours of lectures a day, on a variety of clinical subjects; nevertheless, the University of Alberta's graduates compared well with their contemporaries across Canada. There were two philosophies of medical training then current; one emphasized theoretical knowledge in medical school and the acquisition of the skills of practice after graduation, and the other a greater emphasis on practical care of the patient and bedside teaching. At the University of Alberta the former was practised.

Presumably, this philosophy was based on the assumption that students have a limited number of years in which to acquire all that is known about the theory of medicine and that, once qualified, all they need to add are the skills of caring for patients. Hence, the teachers of that persuasion aimed to ram as much knowledge as they could into their students "once in a lifetime." This was not such an unreasonable philosophy when one realizes that, for those who entered medical school in the latter half of the 1930s, only a few specific drugs were available, such as insulin for diabetes and digitalis for heart conditions: all other treatment was symptomatic or empirical. Biochemistry was still a glimmer on the horizon, some of the vitamins were just being formulated and synthesized, and the first of the 'antibiotics', sulfonamide (M&B 693), was becoming available. Medical knowledge was derived largely from meticulous history-taking and observation and the recording of clinical conditions; experienced physicians were superb at eliciting physical signs, and this skill was combined with a detailed knowledge of morbid anatomy. In schools of the other type, which during the

undergraduate years emphasized the practical care of patients, the acquisition of theoretical knowledge was largely left to the students to achieve through reading, watching outstanding clinicians on ward rounds, listening to senior house staff talking by the bedside, and taking such lectures as were available.

By the 1950s much had changed: there was a large volume of factual knowledge; the emphasis was more toward biochemistry and physiology and less on morbid anatomy; more responsibility was placed on students to learn as opposed to being taught didactically. The philosophy gradually came to reflect the concept of the undergraduate years as being just the start of a continuum of learning throughout a lifetime in the profession.

A Time of Change in Pediatric Care

In 1957 the need was recognized for Pediatrics to go beyond its existence as a division of Medicine, to become an autonomous department within the Faculty and the University Hospital. It was considered imperative that young patients be admitted to a children's ward rather than placed according to their disease process in adults' wards, and that the staff caring for them should be trained to understand the care for children rather than regarding them as miniature versions of adults. Also, it was now considered necessary to care for the child as a whole, and to include the family in the care as much as was practicable, regardless of the nature of the condition that precipitated the child's admission to hospital. This meant radically changing the grossly restricted visiting hours then in effect, the addition of schoolteachers to enable children admitted for more than a few days to keep up their schooling, and an increased opportunity for more people from outside the Hospital to participate in care. A co-ordinator of volunteers was needed, a person familiar with developmental and play therapy, to co-opt volunteers and organize their widely varying contributions.

To achieve all this necessitated changing the physical layout of the children's ward. In the interests of 'total care', an isolation unit was necessary so that children who acquired infections while in hospital could remain there and those suffering complications of, say, measles or chicken pox could be admitted. Another necessity was a pediatric psychiatric unit, for short-term admissions for diagnosis and planning treatment; a pediatric psychiatrist was to be regarded as an integral part of the pediatric team, a contributor to overall care. And so the list of necessary changes grew: imagine the details of new admission procedures, pre-admission visits, the design and provision of special facilities for laboratory procedures, and so on.

Providing the special facilities was hard to achieve in a general hospital, and it says much for the co-operation of the directors of radiology, laboratories, etc., that, within the limitations imposed by providing all services in a general hospital, they were able to go a long way toward the objective. For example, a radiology technician trained in pediatric work could obtain better co-operation from the child and get far better x-ray films; more important, the child was not frightened out of his wits. Biochemical tests, by and large, required 10 ml or more of blood, an amount often hard to obtain from an infant; in certain cases one was forced to obtain blood from the jugular vein, a terrifying procedure for most people but especially for children. Soon, however, micro-methods were developed, requiring only a few drops of blood for some tests, and these of course are now in general use for all patients.

It is true to say that many of the needs outlined above existed or were fast being developed in other centers, but for this particular time and place a lot of them were considered radical changes. The ultimate goal was to provide, within the Province, one center of excellence where people could come to observe or train and in which medical students would see and learn to practise a high standard of

care. The changes were essential for teaching both undergraduates and postgraduates. It seems strange that the care of children in hospital is still the subject of discussion as each new generation 'rediscovers the wheel', but, fortunately, most people have progressed to the realization that the best objective is to keep children well and out of hospital altogether.

Teaching students or training residents in the care of only inpatients had its limitations: it showed them only a fairly small percentage of children, those with acute or serious disease. Although such conditions are more dramatic, and hence have greater appeal to undergraduates and junior residents, they represent but a small part of the care and upbringing and the development of children. To provide a wider perspective, it was necessary to provide facilities for children to be seen in a relatively normal environment, such as an outpatient clinic or, better still, in the home. By 1957, prepaid medical insurance covered about 70 per cent of Alberta's population. Before the advent of this insurance, the traditional source of outpatient care for those unable to afford it was in doctors' offices: most doctors accepted that a percentage of their patients could not pay. Now it was anticipated that, as in other centers, at least some of these indigent families would appreciate the benefits of attending a pediatric outpatient clinic, and that children with chronic disabilities such as mental retardation, or cerebral palsy or other motor problems such as the after-effects of poliomyelitis, could be treated as outpatients. The advantage of including children with chronic disabilities for teaching lay in the need for comprehensive assessment by a number of people of different disciplines. Moreover, the child's family had to be intimately involved in care and treatment given in the home, and the community became involved by reason of its responsibility for ensuring transportation and special facilities for recreation and

education. Thus, the pediatric clinics not only greatly enhanced the breadth of teaching in all related disciplines but also overcame any stigma of inability to pay (and, as a result, sometimes deleterious effects of reluctance to seek medical help) and provided community supports. Undergraduate students could also gain experience in a pediatrician's office, although it was realized that this was an added burden in a busy office, seriously slowing service and reducing the amount that could be provided. It was to the credit of all those whose co-operation was needed that it was possible to use all of these approaches.

In my view it was equally important at that time that the work of a department of pediatrics should not be confined to a hospital or university and be looked on as some sort of ivory tower. I believed that our department should become an integral part of services to the Province and local communities, a center for development and information and a resource to which people could turn for expertise and practical advice. There was no intent behind this to build an empire (as I am sure some suspected!): for one thing, members of the Department were far too busy to try to run all these endeavors—some had to limit their efforts to consultation and advice, and the full-time members had to undertake the considerable amount of administration required to set up the facilities, as well as continuing teaching and clinical work. It was not only a question of getting things set up, but also constant vigilance to maintain the standards. It was my practice that, once goals had been set, we got down to specifics and drew up detailed plans. It was not always possible, or even expedient, to obtain implementation immediately; it was far more important to be prepared for the time when all the factors made it expedient to present the proposals. Sometimes this meant waiting up to 2 years before the moment was 'right': often it was necessary to start with less than the ideal and hope to expand later.

In short, it was not just the efficacy of the proposal itself that determined whether it came to fruition—it was also the timing and method of presentation.

Besides teaching, administration, clinical care and keeping abreast of advances in pediatrics, the Department's staff also had a responsibility for doing and encouraging research. My own experience was in teaching and clinical work; hence, I tended to concentrate on clinical studies. It was also important to add to the full-time staff some people who were trained in basic research: whether one liked it or not, departments within a faculty were—and still are—judged in part by the papers they published and the amount of research funds they obtained annually.

The foregoing is a background for an understanding of both the way in which services developed and their speed of development and the restraints imposed. Pediatrics at the University Hospital (and, for that matter, all other departments in the Faculty) were on the brink of an enormous explosion in growth. Whereas the methods had been acceptable by the standards of their time until about 1947, they had lagged in comparison with what was going on in many other centers in the post-war years. It has to be remembered also that many people who had experienced the Depression in the 1930s were now in positions of responsibility in the Faculty, the University, and the Government: after so many years of restraint, it was hard for them to accept that the greater expenditures were being outpaced by the means to effect the changes. These 10–15 years were a halcyon period, through the 1960s and into the '70s. There may have been some lag in getting started in Edmonton, but within a remarkably short time the Faculty as a whole not only became competitive with similar facilities across North America but in some instances surpassed them. That did not mean money was squandered or even obtained too easily; and, naturally, the politicians' preference was still a single capital

expenditure on highly visible objects, such as roads and buildings, rather than the unseen and unsung services entailing ongoing budgets.

In 1957, funds were provided through the Dean to enable me to visit several departments of pediatrics in western cities, including Salt Lake City, Denver, Portland, Seattle and Vancouver. I had formulated a lot of plans for the future before visiting these centers: it always seemed to me a sterile approach to go elsewhere with a blank mind in the hope of being provided with answers and to assume that such could be transferred successfully to a different environment, but rather to keep one's mind open to adaptation, refinement, and additions to one's own ideas.

At that time there was a common pattern running through the way in which these five university pediatric departments were developing. To start with, they had accepted the need for full-time staff in the discipline by the early 1950s, and it was not uncommon to find 10 full-time faculty together with numerous teaching and research fellows and residents at all levels of seniority. (It is relevant to mention that, at the time of my appointment, the Dean had not anticipated a need for more than about four full-time faculty members in our department.) Second, at all five centers the departments I visited were producing excellent work and would be considered by many to be more successful in their approach than we had achieved through the slower initial development in Alberta. However, the majority of their full-time faculty were supported by grants—a precarious method, particularly if the grants had to be renewed annually, one that didn't allow for any downturn in the economy. In 1957 this was probably an over-cautious view; as it turned out, there were a good 10 to 15 years of unrestricted budgets, a time during which the situation could be stabilized. Nevertheless, in many centers such tenuous financing did become a problem, but not until well into the 1970s. Furthermore, Canada had never had

the plenitude of research money enjoyed in the USA; indeed, it is to the credit of our American neighbors that they allowed some of their funds to support Canadians in Canada.

This was an era of "publish or perish," due largely to the need to make frequent re-application for grants. Fortunately, because of the vast amounts of research money available in the USA, there was less discrimination in approving so-called research projects. It may be that such a comment smacks of 'sour grapes'; however, it is also a matter of philosophy in the approach to research. To oversimplify two such approaches, one can spend a lot of time postulating and refining a hypothesis and then design an experiment that uses the simplest method to test it, or one can come up with a vague idea and apply elaborate, often-expensive means in a wide search, hoping that something will come of it. Who is to say which is the more productive, particularly when limitless money is available? The illusion persists that, because some remarkable discoveries have been serendipitous, it is all a matter of luck. This has never been so. Discoverers may refer modestly to an achievement as something they came upon by chance, but in fact there was no chance to it: had they not been thinking deeply, the significance of this side observation would have gone unnoticed; for example, the brilliance of the discovery of penicillin lay in Fleming's recognition of an unplanned observation, his awareness of the unexpected. However, there is the need after the initial discovery for development and adaptation, and making products available, and in this aspect we Canadians seem to lag behind.

The other reservation I had about the trends in development in the other institutions' departments of pediatrics was their emphasis on subspecialties. True, this was a necessary development, but it ran the risk of concentrating on the disease rather than on the child as a whole. It was really a matter of degree, the extent to which the subspecialties were stressed. The tendency at that time was to

appoint established research workers as heads of departments, emphasize research and publication, and concentrate intensively on subspecialties, a state of affairs that detracted from excellence in clinical diagnosis, treatment, and care for the patient. In subsequent years these overemphases were corrected—indeed, the wheel has now gone full circle, to publications and conferences praising the generalist and holistic approaches to care.

The First Eighteen Months, January 1957 to June 1958

The forum for discussion of recommendations for change in policy or physical structure of a department in the Hospital was the Medical Advisory Board. This was chaired for some years by the elected President of the Medical Staff, Dr. Ken Thompson; this position, which demanded a lot of hard work and considerable diplomacy, was a task for which he was eminently suited. The Medical Advisory Board included the heads of all the departments, administrative staff, the Dean of Medicine, representatives of the University, and others, and so its recommendations to the Board of the Hospital carried considerable weight. Gradually, over the years, as part-time clinical heads of departments were replaced by full-time members, the latter became the majority on the Medical Advisory Board; thus, a full-time head of a clinical department, by virtue of the terms of his appointment to the Hospital and his voice on the Board, was in a powerful position.

It says much for the tolerance and goodwill of the clinical staff, who were far more numerous and whose livelihood could be affected by a department head's decisions, that no serious rift had developed between full-time and practising staff. The situation required considerable tact and co-operation on both sides. Certainly there were differences of opinion between the full-time staff members; but this never reached the stage of becoming personal, when all communication could be lost. Indeed, the minimal degree

of personal animosity throughout the medical profession in Edmonton was unique in the West.

The key person, the one whose support was essential in achieving change, was the spokesman for recommendations going from the Medical Advisory Board to the Board of Governors; this was the Medical Superintendent of those days, Dr. Angus McGuigan. In view of the radical upheaval associated with the introduction of full-time staff, it is greatly to his credit that he could go along with many of the changes that ensued. I am sure that at times he must have looked back with some nostalgia to the days of working with a small, tightly knit group who had known each other for years. Suddenly, all of this had changed: new appointees appeared on the scene, all competing for dollars for their own departments, and full of ideas—many of which were an implied criticism of the status quo. It was not surprising, therefore, that Angus could be prickly and at times stubborn. In any event, he had to be treated with respect and tact if objectives were to be attained.

All in all, Angus McGuigan was quite a character. One of his absolute rules was that house staff (and, doubtless, attending staff) should not smoke in hospital corridors, and many times I saw him raising the roof over some terrified intern he had caught—but usually with one hand behind his back, holding his own cigarette! With Angus I found it best to avoid the direct approach. When confronted head-on, often he would color up, changing gradually from pink to deep red and ultimately purple with speechless rage, at which point the supplicant might just as well abandon all hope of achieving that particular objective. The ploy I used that seemed most successful was to catch him in a moment of leisure, and sit down for a casual chat—something he always enjoyed. At some point in our conversation I would relate some structural plan for part of a pediatric ward, or some diagnostic service or change in procedure, and leave it at that. More often than not he would send

for me some weeks later and say that he had been thinking about thus or so and ask my opinion. Naturally, I welcomed such 'ideas'; I could then produce the detailed plans I had drawn up earlier. The success of this approach was not that Angus wanted the credit for new ideas, I think, but rather that he could look at the proposal from all angles and mull it over thoroughly before having to commit himself.

Angus McGuigan was an interesting person, erudite, and I am sure widely read: in his earlier years he had been a schoolteacher, and it was only later that he had had enough money to put himself through medical school. Angus was astute and knowledgeable; with all of what I (and maybe others) found to be endearing characteristics, he was nobody's fool. It was with grave misgivings that he had allowed me to separate off six or eight beds on the pediatric ward as an infectious-disease unit so that children with complications of infectious disease could be admitted, and he would often telephone me and question my judgement when he read the list of admissions. Dr. McGuigan's reluctance was understandable—he had been reared in the days of isolation hospitals, a time when any cross-infection could be lethal. I, however, was placing continuity of care in one place in the context of a new era in medicine; also, I felt that experience with such conditions was essential for teaching. It so happened that an 8-year-old Chinese boy from southern Alberta had been referred to me. The patient's father, who ran a restaurant, had lived here for a number of years and, like so many of his compatriots, he periodically returned to China to visit his wife until he could afford to bring all of his family to Canada. Thus it came about that the patient had spent the first 6 years of his life in China. The child was referred here because of weakness in one forearm and hand, corresponding to the muscles supplied by the ulnar nerve; over the cutaneous distribution he had a peculiar rash, unlike any I had seen before, that

spread slowly peripherally. From the dim recesses of my memory it came to me that leprosy produces skin and nerve lesions, and perusal of the textbooks confirmed my opinion. I thought it a fine opportunity to have some fun with Angus, as this form of leprosy is not infectious, so I telephoned him: "Dr. McGuigan, do you mind if I admit a patient with leprosy?" There was a prolonged pause at the other end, while I was laughing up my sleeve. Then Angus took the wind out of my sails completely by remarking that leprosy showed itself in two forms, and he presumed that my patient had the noninfectious type!

I owe a lot to Dr. McGuigan, not only for his support in achieving change but also because it was through him that I learned the art of 'politicking', a practice that has stood me in good stead. It was he who taught me that it is the manner of approach and, most important, the timing, that determine the success of one's plans.

In June 1958, 18 months after my appointment as director of the Division, Pediatrics became a department. The annual reports covering that period evidence considerable change in organization and the physical structure of the pediatric wards. At the time I arrived, in January 1957, plans were in hand for changes in the undergraduate curriculum. Increasing the full-time medical staff, had been added to the University Hospital but had become superfluous with the advent of polio vaccines. Thus, the specifics for the actual planning was all that was needed to generate change.

Soon after I was first appointed here the College of Physicians and Surgeons of Canada accredited the Division for 2 years' residency training in pediatrics for any number of people. On the 1st of March 1957, the first senior resident was appointed, and in June that year a junior resident was added; three further positions were filled the following year. The number of pediatric beds rose from 60 to 125; this included 20 beds for school-age convalescent and long-term patients, thus creating faster turnover for the acute

beds and enabling us to introduce fuller non-medical programs such as schooling and occupational activities. There were 1887 admissions in the 12 months 1957–58; about 50% were to pediatricians, 41% to surgeons, 6% for cardiovascular investigation, and 3% for treatment by internists, psychiatrists, and dermatologists. All admission procedures were carried out by pediatric house staff, alone or in collaboration with house staff from other departments. Interns' experience in pediatrics was increased from a 1-month to 2-month rotation. In July 1957, the Division of Pediatrics became responsible for the neonates' nurseries and care for premature infants; this was not without strong opposition from some obstetricians.

By early 1958, 150 children were being seen in the pediatric outpatient clinic each month. Thanks to a generous grant from the Co-ordinating Council for Crippled Children, one of the part-time staff, Dr. Neil Duncan, visited pediatric cardiac centers in Canada and the USA; upon his return, a monthly outpatient clinic in cardiology was initiated. Another part-time staff member, Lloyd Grisdale, was appointed chairman of a committee set up by the Alberta College of Physicians and Surgeons to carry out long-term studies into perinatal mortality at every hospital in the Province.

During the first 18 months a full-time assistant professor of pediatrics, Bill Taylor, joined the staff; one of the conditions of subsequent confirmation or tenure was that he should pass the Fellowship examination in pediatrics. At that time the Royal College had two specialty examinations—for certification, which every specialist required to be recognized as such in his or her province, and the Fellowship. Very few pediatricians took the latter, which was a much stiffer examination; in Western Canada there were only a handful of Fellows. The most senior (i.e., in years since becoming a fellow) who comes to mind was Dr. Sidney Israels of Winnipeg, and he had taken the examination in internal medicine.

In 1957 I had taken only certification; hence, when I insisted on the stipulation of a Fellowship, Dr. Taylor, who was a close friend, raised the question of how I proposed to achieve the same end! (As it happens, I was honored a few years later by bestowal of the Fellowship without examination.) To me it was essential, in building up the full-time pediatric staff—and, indeed, to encourage more of our trainees in the future—to aim for the highest qualification obtainable.

During this first 18 months, two more part-time staff were appointed to the University Hospital. This raised the number of active staff engaged in teaching to 13, including two sessional instructors. Additional undergraduate teaching time for pediatrics was obtained through changes in the curriculum. Previously, I believe students had spent a total of only about 96 hours; from now on, they were going to play a more active part in their training.

The fall of 1958 saw the introduction of a greatly changed undergraduate curriculum for the second and third years, the result of enormously hard work by the curriculum committee. Students at the University of Alberta had to sit both the MD and the Medical Council examinations and, as members of the Department gave the former, which were mainly in essay format, it was possible to identify those parts of the subject with which students were having difficulties. Now, the curriculum required our input in the second year; this consisted in a new, interdepartmental introduction to the Medicine and Physical Diagnosis course, in which 16 lectures were given in physiology of the newborn and in growth and development. In their third year, students were allotted one trimester of 11 weeks, including 9 weeks with the Department of Pediatrics; in the first few weeks the emphasis was on taking histories, examining patients, and the principles of orderly solution of clinical problems. Throughout this third year the objective was sufficient clinical experience to make students' reading and

discussions meaningful. To this end, the students were allotted patients (without responsibility for them) and the records were discussed and corrected, and concepts of preventive health and long-term care were introduced by way of outpatient clinics, local well-baby clinics, and visits to the School for the Deaf and the cerebral-palsy and child-guidance clinics. This introduced the students to the idea of comprehensive care by various disciplines, all working together for the overall good of the patient; however, the idea that someone other than a doctor might have some input into a child's care was only slowly appreciated. Fourth-year students did a 2-week internship in pediatrics, living in at the Camsell or University Hospital.

After the fall of 1958 the undergraduate training programs changed only in detail until 1970, when another major upheaval occurred. Postgraduate programs were developed and fine-tuned in similar manner. I don't remember in which year we received the Royal College's full accreditation for training pediatricians, but we never had any difficulty arranging a residents' full 4-year training program in Alberta—a happy situation that prevailed until the late 1970s.

Chapter 2

1958–1971: Years of Development

Coming of Age as a Department: Development of the Specialty

J. KENNETH MARTIN, MD, MRCP(Lond), FRCPC
Director of the Department of Pediatrics, January 1957 to June 1968

Dr. A.G. Stewart, the third person appointed to the full-time staff of the Department, was a biochemist. He contributed much to basic research and organized the instruction of residents and students in the techniques of this discipline, which was expanding very rapidly both technologically and in clinical application.

Another field integral to pediatrics in which rapid progress was being made was genetics, and we were most fortunate in having Dr. Margaret W. Thompson, a Ph.D. in this discipline, as consultant; she did research and provided a counselling service for the University Hospital and in 1961 was appointed to part-time faculty. After Dr. Thompson and her husband moved east, her work was taken over by Dr. Judge, an internist with special training in genetics. And then, in 1964, we obtained the full-time services of Dr. Peter Bowen, also an internist, who became internationally renowned as a medical geneticist and identified several 'new' genetic disorders and was director of the Division of Medical Genetics for some years. When Genetics was first established, the laboratories were in the old wing operated by the Department of Veterans' Affairs, attached to the University Hospital; its aims were to provide service within the Hospital generally, and thus consulting services for the Province, as well as basic research and training for the Department of Pediatrics.

The development of children's services was expedited by the sessional appointment of several clinicians, a measure necessitated in part by restricted funds and partly because of the shortage of

suitably qualified staff willing to move to Edmonton. Later, of course, as the standards of our medical school became better known, it was easier to attract persons with an established reputation. Meanwhile, the local sessional appointees made an excellent contribution—while enabling the Department to guide the training of selected residents, with a view to their returning full-time.

Dr. K.A. Swallow helped greatly with the work in outpatient clinics, preventive pediatrics, and health for children in its broadest sense. In 1962, upon obtaining a master's degree in public health at Johns Hopkins, she returned to take over the Province's Poison Information Service for Northern Alberta and started a well-child clinic for the children of university students. The latter, which was funded by a grant from the federal Department of National Health & Welfare, was in the Students' Health Services Building, close to the University Hospital. When Dr. Swallow left, in 1965, her place was taken by Dr. Lois Stayura, who was appointed full-time to the Department. Dr. Stayura, a graduate of the University of Alberta, had taken most of her postgraduate training in the USA, in particular at the Mayo Clinic. She had been an excellent undergraduate student here, and I re-established contact with her when I was an examiner for the Fellowship in pediatrics, at which her performance was outstanding.

Dr. Catherine Lee, who later married Dr. Peter Bowen and, with him, established a computerized records system for medical genetics, came here as a Medical Research Council Associate in genetics in July 1965. In 1967 the Department gained two more staff members: Dr. B.A. Chernik, another MRC Associate with a Ph.D. in genetics, and Dr. Peter Wilcock (now deceased), a full-time appointee with a fellowship in pediatrics, who was one of our own trainees.

By this time it had become necessary to split undergraduate training into three main groups—at the University Hospital, the

Royal Alexandra and Glenrose School Hospitals, and the Charles Camsell. Although all of the hospitals in Edmonton had been used for teaching, this arrangement had been fairly informal; but now the expanding pediatric services necessitated detailed planning for both undergraduate and residency programs. In 1969, Canadian university departments of pediatrics became responsible for the training of pediatric residents in all hospitals in their area. In Edmonton, teaching and training at the Camsell was linked to that at the General Hospital, with Peter Wilcock in charge of the program; he had a teaching fellow and was responsible for several residents. Dr. George Eddy, who had come to Edmonton to join our staff in 1960, became full-time with responsibility for the Royal Alex and Glenrose programs. Later, a fourth teaching center was set up at the Misericordia Hospital, under the guidance of Dr. Charles Fried, a dedicated sessional pediatrician.

Dr. A.G. Stewart, in pediatric biochemistry, moved to Halifax during the 1968–69 session; and Dr. E.E. McCoy, who took his pediatric training in Canada but had spent many years working in pediatric biochemistry and microbiology in the USA, joined the Department as professor for pediatric research. Dr. McCoy brought with him a great reputation, having been a Markle Scholar in Medical Science and recipient of a Research Career Award from the US Public Health Service; when I left, he succeeded me as head of the Department. In 1970 Drs Pabst and Jones joined the full-time staff; both were graduates and trainees of the University of Alberta and had their Fellowship, and had completed special training in immunology and gastroenterology respectively. Thus, the full-time staff had grown from a single member in January 1957 to a total of 10 in July 1971, in addition to which there were now 4 teaching and research fellows and an average of about 10 residents in training.

By 1971 all of the subspecialties were covered by full-time or sessional staff. The latter merit special mention, for their

outstanding contribution to our expertise. One of the earliest sessional appointees was Dr. Neil Duncan, in pediatric cardiology; he worked as a member of a team with full-time cardiologists in the Department of Medicine, having established his competence in the area with the aid of travel grants to attend courses and through intensive application within the University Hospital. Another was Dr. E.W. Gauk, who took his early training in Edmonton and postgraduate studies in internal medicine and neurology in Toronto and returned here to cover pediatric neurology. A third was Dr. S.J. Tkachyk, who had a special interest and training in allergy.

As time went on, more and more of the pediatricians entering practice in Edmonton had taken at least part of their postgraduate training at this university. All were attached to the Department, and most of them had some privileges at the University Hospital even if their main affiliation was at another one.

I have related the names of some full-time and sessional staff because they help to illustrate the development of research and expertise for the subspecialties in this city and for the Province as a whole. In addition, one cannot overemphasize the part played by local practising pediatricians in the development of the Department, establishing any reputation gained and teaching both undergraduates and house staff. Any lack of mention by me of individuals who gave their services so willingly is due partly to their number and partly to lapses in my memory, and I refer my readers to the record of their contributions and achievements in the annual reports of the Department and affiliated hospitals.

The number of pediatricians in Edmonton started to increase quite rapidly after World War II, with the return from the Forces of people such as Lloyd Grisdale and Brock Armstrong, who did most of their work at the University Hospital. Dr. Alf Gander provided leadership in pediatrics at the Royal Alexandra Hospital, and, until Dr. Eddy was appointed full-time, he organized the teaching for

undergraduates as well as the training programs for interns and residents there. Drs Beauchamp and Poirier carried any teaching at the General, as did Dr. Conradi and subsequently Dr. Mitchell and others at the Misericordia. At the latter, although Dr. Fried was always a sessional appointee he devoted as much time and energy to teaching and training as any full-time member. In 1957 Edmonton had 11 practising pediatricians; by 1971 there were 37 men and women registered as pediatric specialists, a reflection of changes in outlook and the prosperity that had started in the late 1940s.

I believe that, as a Department, we were a united and close-knit group, with no major interhospital rivalry by the clinicians or between full- and part-time staff. Every pediatrician had an appointment in the Department, and each made a full contribution; even the subspecialties, which depended on referrals from the practising staff, were supported. This not to say there were no differences of opinion or lack of friendly competition. One cynic asked: "How do you stand it, Ken? The only reason anyone comes into your office is to lodge a complaint or ask for more money." I preferred to put a more positive construction on my contacts, in that I was kept informed of the thoughts and aspirations of most people attached to the Department. And I had one source of information I could depend upon for amusement—a staff member who, after a few social drinks, unfailingly told me just what he thought of me, my actions, and the Department in general!

It was not only to the Faculty and their affiliated hospital that the practising staff made their contribution. For example, there were those whose standing among their fellows was high and brought honor to themselves and aided recognition of the Department. Associating the Department with the community and gaining its respect for our expertise enhanced our standing beyond the local purview. Brock Armstrong was president of the Canadian Pediatric Society. Lloyd Grisdale was not only highly respected in medical

politics, serving with the provincial government after he left his full-time appointment here; in turn, he was chairman of the Committee on Examinations for the Medical Council of Canada, president of the College of Physicians and Surgeons of Alberta, chairman of the Board of Directors of the Canadian Medical Association and its president for 1975–76. These are but two examples of our staff's commitment beyond the Faculty; there were many others whose expertise has been in demand on committees, locally, provincially, and nationally, and there are few facets of care for children anywhere in the Province in which our pediatricians have not been involved.

Of the pediatricians who entered practice in Edmonton, took other appointments in the community, or practised elsewhere in Alberta, about 20 took part of their training in the Department. They include Doug McPherson, one of our first residents, Brenda Schmidt (née Devlin), who was our first teaching fellow, and Gill Turner, who practised in Calgary for a while before settling in Australia. There were Mario Tedeschini, Andy Stewart, and Bob Shea; Bob Chen, who had a special interest in endocrinology and metabolism; Ed Burchak, Christine Zalesky, Ishwar Singh and John Aylward; Vic Ratzlaff, who became a consultant in Red Deer; John Godel, who went overseas for some years but has now returned to Edmonton; Orest Ulan, who took further training in neonatology; and Reuben Weinberg and M.R. Turton.

Don Spady returned to join the full-time staff just after I left. Jack Popowich remained in Edmonton, and Jack Reynar practised in Brooks. Patrick Kimmitt, an Albertan, returned here to practise after pediatric training in eastern Canada and was a valued member of the Department from 1958 onward. R. Gobius assisted with genetics until he took an appointment with the World Health Organization, and Marvin Mitchell came to Edmonton after training elsewhere. Harold Eist, who later switched to psychiatry, and Antonietta Rouget, who assisted in the programs at the Misericordia and is now

at the University Hospital and a local government consultant, took part of their specialty training here. I only regret it is not practicable to mention here all of the residents, some 60 in all, whose company I enjoyed during the nearly 15 years I was with the Department.

Although not necessarily an indication of quality, papers published and scientific addresses given by its members do help to make a department known and, from time to time on account of their erudition, add honor. During my first 6 years, on average some 6 to 9 papers were accepted for publication and 20 to 30 scientific addresses were given annually. By 1971, the papers accepted numbered 16 and presentations over 30, to a maximum of 57 in any one year. Another parameter taken into account in reviewing a department is the amount of research funds obtained. This started out at $20,000 in the early years and rose to close to $60,000 by 1971. In addition, some $20,000 to $30,000 in service grants was obtained each year until about 1967, when the Province assumed financial responsibility and most of these funds were withdrawn. More will be said later of the pediatric services funded by these grants.

At the University Hospital, all of our staff co-operated in the rapid upgrading of children's services. Much against "the better judgement" of administration, and particularly the caregiving staff, visiting hours had been radically broadened, and by 1960 many facets of care had been changed. Parents were now included in decisions about care for their child and when feasible could help with it, the children were continuing their schooling while in hospital, volunteers and play therapists helped alleviate emotional problems, and the pediatric psychiatry unit was providing full services. In 1962 the Edmonton Public School Board assumed all responsibility for education, thanks to the farsightedness of the superintendent of schools, Mr Baker. Also, a third teacher was added, for emotionally disturbed children.

Recognition was growing that children are still members of the family unit, with non-medical as well as medical needs, while they are in hospital. The number of volunteers rose steadily, and by 1963 they were giving over 5000 hours of their time annually. The Hospital provided excellent playrooms on each ward, with furnishings and equipment suited to each age group, and the children's library amassed over 1000 books. During 1957–71, there were three nursing supervisors of Pediatrics, about four co-ordinators of volunteers and play therapists, and some eight teachers, each dedicated to the task at hand and all contributing ideas to improve the care of their patients. Where possible, children spent half a day at the Hospital before admission, to familiarize them with all aspects of their anticipated care. Although there was never space for parents to room-in, whenever possible a bed was provided for the parents of critically ill or dying children.

Although responsibility for neonates at the University Hospital was shifted to Pediatrics in 1957, and a neonatal intensive-care unit to serve the entire Province was set up in 1968, the largest number of deliveries each year took place at the Royal Alexandra Hospital. Thus the number of pediatric beds reached a peak of 115 at the University Hospital, compared with 125 at the Royal Alex (where a new maternity and children's pavilion had been opened), and there were at least 60 beds each at the Edmonton General and the old Misericordia Hospitals. To these facilities must be added the Camsell Hospital and, later, the Glenrose School Hospital. In all, there were over 400 beds.

Around the mid 1960s, when pediatric bed occupancy peaked and the shadow of financial restraint had not yet appeared, what was probably a once-in-a-lifetime opportunity for a children's hospital in Edmonton began to take shape. This arose from a conjunction of events: the planned move of the Misericordia Hospital, a drop in the occupancy rate at the Edmonton General, the

desire of the federal government to 'unload' from Indian Affairs the Camsell Hospital, and discussion of proposals for a school-hospital for chronically handicapped children. The key to the plan was the University Hospital's need for more beds for other services: its pediatric beds, along with the pediatric services at the Camsell and the proposed school-hospital, would have made the scheme feasible irrespective of any plans at the other three general hospitals. I had quite a lot of influence in regard to the University Hospital and the proposed school-hospital, but the plan still required the Faculty's approval and specifically the Dean's support to gain the Camsell's services—the corner-stone to having sufficient acute beds and outpatients.

My schemes aborted before they saw the light of day. This was mainly because I never discussed with anyone proposals I had in mind, until plans were complete and I was certain the timing and my contacts were propitious. I was aware that the Dean was the central figure through whom discussions would be started with the federal government in regard to alternative uses for the Camsell. I had assumed—wrongly, as it turned out—that he would consult the heads of departments that used the facilities at the Camsell: he flatly rejected any part in discussions, a fact I learned only too late.

In fairness it may be said that, even if the scheme to have a children's hospital in Edmonton had not aborted then, there would have been many potential pitfalls. Certainly, there are great advantages to having a single dominant children's center, but at that time one could not have obtained support for siting it on or adjacent to the campus. Even if that site could have been made palatable to the profession at large, which was highly improbable, the provincial government and in particular the Ministry of Health (from which the bulk of the funds would have had to come) would have opposed it. Alternatively, siting the children's center well off campus would have entailed loss of liaison and valuable co-operative ventures with

other clinical departments of the Faculty, in particular the Departments of Medicine, Obstetrics, and Psychiatry, with whom we enjoyed a network of services and research. It would also have weakened, and perhaps broken, some of the links we had established with the basic sciences, the Faculties of Science and Agriculture, and the McEachern Research Centre. Indeed, to this day I cannot honestly say which arrangement would be the most advantageous to the department of pediatrics.

The volume of inpatient teaching is more clearly indicated by the number of admissions or discharges than by a bed count, whereas suitability for teaching and training is better judged by the types of cases. For instance, there would be little value in teaching undergraduates or training interns, or even residents in their first 2 years of general pediatrics, in highly specialized facilities such as may occur in university-centered hospitals. What is needed for these purposes is a broader spectrum, particularly of the commoner diseases; the highly specialized center becomes appropriate only for subspecialty training and research. Fortunately, this was not a problem in Edmonton, for even if the University Hospital's pediatric admissions had become increasingly of an 'exotic' or rare nature, there were plenty of beds in the other hospitals. This held true even when the number of admissions fell drastically during the late 1960s, a development that upset all previous projections for bed requirements. This drop marked the end of the first-generation of the post-war 'baby boom' and the advent of 'the pill', coincident with a trend to use day-centers for investigation and therapy in an attempt to avoid the potential risks and cost of inpatient care. Thus, admissions to the University Hospital's Department of Pediatrics, which totalled 2625 in 1957 and reached a peak of 4000 in 1963–64, declined gradually after that.

Residency training was strengthened continually by the incorporation of proposals from staff and trainees alike, and there

was no doubt the training met the needs for a career and made the person capable of passing the specialty examinations. I used to try to give the residents a 24-hour lead on private patients admitted under my care, provided the urgency of the situation allowed for this. They had to take a history and record the physical findings, and state their primary diagnosis and the reasons for making it. Although I approve of recording alternative diagnoses, I believe that one, and only one, should be explored at first; this way, trainees can see whether they are right or wrong, and why. It is all very simple to list 6 to 12 differential diagnoses, one of which would almost certainly be right, but this makes for sloppy reasoning and the person can always claim that his or her diagnosis is never wrong – in my view it is never right, either.

I always taught that the diagnosis should be made on the history. If one has the patience to listen to the mother, she can nearly always reveal the diagnosis to the physician, albeit in lay terms: the aspects of the illness that may be a cause of worry to her are often irrelevant to the main problem, but, buried in what to a professional is irrelevant, there is nearly always a clue to the diagnosis. Students then learnt that the physical examination was to confirm or disprove the diagnosis, and that laboratory tests were to be used selectively to specify in greater detail the problem at hand. I was very hard on any student or resident who ordered irrelevant tests, a practice that encourages trainees to hope the laboratory will make the diagnosis for them but, more often than not, leads them to follow-up a lot of red herrings.

My method of teaching was not a one-way street, however: students and residents drew my attention to things I had overlooked, and often gave me a better insight into the problems. When it came to the rarer diseases, I had the advantages of wider reading and experience, but these were assets that I hoped they in their turn would acquire. Apart from the knowledge that one uses

daily, I always felt that only exceptionally brilliant persons (or parrots with a photographic memory!) could memorize all they read. I had therefore developed an excellent cross-reference system that enabled me to find the details quickly on subjects I had heard of but not encountered. One day, after discoursing on a child with a rare condition, while walking along a corridor parallel to one in which the senior resident and interns were walking, I heard an intern remark on my brilliance and express astonishment that I retained so much knowledge. The resident, who had worked with me longer (I think it was Bob Shea), merely gave a dismissive grunt, then said: "Don't you believe it. The old bxxxxx got to the books before we did!"

EXPANSION AND SUBSPECIALIZATION

Specialty training developed gradually in this country. The Royal College of Physicians and Surgeons of Canada initially outlined the requirements for certification in a specialty and later specified the number of years and type of training required for eligibility to sit the examinations for the Fellowship. By the early 1960s, more details of training were being worked out. Eligibility of an institution to seek accreditation for training rested on various requirements, including the minimal number of admissions per resident per year and, perhaps more important, the minimal requirements for outpatient experience. For example, an approved center should have not less than 1000 outpatient visits (including emergencies) per resident for 1 year of training, and 2000 such visits per resident annually for the 2nd year of residency. For the pediatric residents in Edmonton, these recommendations amounted

to a need for some 200–300 pediatric beds and some 10,000 outpatient visits.

In order to provide more suitable training, and later on to meet the Royal College's recommendations, emphasis was placed on building up the general outpatient clinics. From an initial attendance of 1800 children annually at one clinic a week, by about 1962 the attendance had risen to 3500 and the need for clinics to three a week. This attendance then remained fairly static until 1967. In that year, the introduction of a national health service, covering the entire population, allowed people to choose their own physicians and attend them in their private offices. This virtually eliminated the need for general outpatient clinics.

Specialty clinics, such as cardiology, epilepsy, neurologic disorders and respiratory diseases, still served a need, but for a very small number of children. Thus, alternative means of giving students and trainees access to children's problems were sought.

The problems with diminishing outpatient contact was overcome in part by having students or residents spend time in pediatricians' practices, but this.hindered the physicians considerably as the teaching was time-consuming and the tasks they could assign to trainees were limited. An alternative was to expand the well-child clinic for university students to that of health care for pre-school children; later, a 24-hour service for total child care was inaugurated for a limited University based population. In effect, this was a pediatric practice; but again, all parties—including the practising pediatricians on whose territory this encroached—were most co-operative.

Overall, at that time in Alberta (or for that matter in Western Canada generally) there were very few services beyond doctors' offices. The multidisciplinary approach of comprehensive assessment of handicapped persons was nonexistent. And, in

general medicine, although there were consultations between independent specialists the concept of a health-care team had been slow to develop: many doctors were having difficulty accepting the idea of being part of a team that included professionals from other disciplines, such as social workers, nurses with special training, and psychologists, and physio-, occupational, and speech therapists.

Reaching Out into the Community

Starting in the late 1950s, in an attempt to provide a broader concept of child care the Department expanded co-operation with external services. Students and residents attended the child-guidance clinic run by the Province, which was intended to assess intelligence and advise on behavioral problems. In 1961, eight beds on one of the pediatric wards (Station 23) were allocated for short-term admission of children who were severely emotionally disturbed; this 6- to 8-week period was intended to cover diagnosis and formulation of a treatment plan. The Department of Psychiatry appointed a pediatric psychiatrist, Dr. Drew McTaggart; and the next year a brilliant pediatrician with great insight into the changing needs of care—the late Jean Nelson—started an outpatient clinic for emotionally disturbed children at the University Hospital.

A few years later Dr. Nelson became Medical Officer of Health for the City of Edmonton. During her tenure in this appointment she completely re-organized the so-called well-baby clinics and expanded the role of public-health nurses, resulting in the application of screening tests for early detection of emotional and learning disorders and hearing and vision defects. This was in contrast to the previous job of the Public Health Department, which had been simply to give inoculations and advice on feeding infants and to examine children for physical defects. Later, Dr. Nelson held

a senior appointment relating to pediatric care in the provincial government.

Here on campus the provision of services for emotional problems of children at the University Hospital enhanced the teaching program and engendered an integrated, more-intensive approach. Because of the close association of the Department with the emotionally disturbed children's unit, station 23, a broader concept of pediatric care in hospital could be demonstrated to students, residents, and caregiving staff. This cast a wider perspective on treating a child as part of his or her family rather than simply dealing with the disease.

It is amazing how astute children can be in calling a spade a spade. We simple adults thought that by treating children with predominantly emotional problems as part of the general population on the children's wards there would be no marked distinction from those admitted because of physical problems. Our illusions were shattered when we overheard two children mentioning that such and such a child was to be treated "with the crazy guys."

The City of Edmonton's well-baby clinics were used for teaching with the co-operation of the Medical Officer of Health and the public-health nurses. In 1962 it was possible to expand such programs into a well-child clinic, set up by Dr. Kay Swallow, for the older offspring of parents attending the University's well-baby clinic. Space for this was provided in the Students' Health Building and it was funded from a National Health grant. Dr. Swallow also started a clinic for adolescents at the University Hospital; by that time it was realized that adolescents, while resenting care in children's units, were far from mature enough to be handled as on adults' wards.

Other community services used for teaching included the City of Edmonton's cerebral palsy clinic and the School for the Deaf, the latter a purely educational facility. The provincial government had

been persuaded to set up the clinics for the treatment of patients with cerebral palsy in Edmonton and Calgary, largely due to the efforts of Dr. Fred Day, an orthopedic surgeon who ran the Clinic in Edmonton. The scope of these clinics was broadened when Dr. Day asked me to attend as a pediatrician, and an obstetrician interested in the cause and prevention of cerebral palsy joined the staff later. In Edmonton, an experienced nurse, Mrs Adelung, was in charge, and the health-care team included physiotherapists, ocupational therapists,and social workers.

It seems strange today to realize that, at that time, hearing defects were diagnosed by only a few interested ear, nose, and throat specialists in practice. The fitting of hearing aids, if any, was left exclusively to the hearing-aid dealers, most of whom had limited experience in this field. As often as not the diagnosis was not made until children reached school age, or even later, and in any event too late to hope they could achieve oral speech. Nonetheless, in the management of children with a hearing deficit in schools for the deaf right across North America, the arguments raged between proponents of purely oral and purely sign language. It is recognized today that the severely deaf require hearing aids and other devices from the first few months of life, and a full program of communication.

When a Speech and Hearing Clinic was finally approved, the University Hospital provided the space and employed a speech therapist and a pediatric social worker. These people were responsible for the pre-school deafness and cleft-palate clinics, which were functioning by 1962, and worked with specialists from other departments who attended as needed. This co-operative approach was used to establish an amputees' Clinic in 1963 and the meningomyelocele clinic soon after.

The Hospital also provided space for community and provincial services, such as genetic counselling and the Poison Control Information & Treatment Centre. The latter, which opened in 1959/

60, and another one in Calgary, were approved by the provincial government. Service was provided by an advisory committee, of which I was chairman; it included a pharmacist, a pharmacologist, and the deputy minister of health. The informational materials supplied to every hospital in Alberta, including reference cards outlining the treatment for poisoning with over 100 substances, enabled their staff to deal with the commoner agents such as Aspirin; further information, on plants, drugs, and particularly commercial products, could be obtained by telephone from the Centre nearer them. At the University Hospital the Centre was manned around the clock by the pediatric resident on call, who in case of need could call upon a number of consultants in various medical specialties and other professions.

Something should be said at this stage about the funding of community and diagnostic services, including screening clinics such as the one for deafness in pre-school children that were set up later. The Hospital (and ultimately the Province) was responsible for the physical facilities, the cost of utilities, and the salaries of a limited number of personnel such as nurses, social workers, and office staff. Until the advent of prepaid medical services, doctors worked for nothing or were paid a fee for service if the patient had prepaid medical insurance. A considerable part of the cost of health care was met by grants from the federal Department of National Health & Welfare (DNHW), for which application was made annually; service grants of this nature reached a total of $30,145 in 1964/65. As time went on, the Province was expected to take over all financing and later there were further cost-sharing schemes under the comprehensive national health service.

It is worthy of comment that, until the 1970s, although Alberta was becoming wealthier each year it was still a recipient of the federal government's equalization payments to 'have-not' provinces. Thus, the funds for many of these projects of the 1960s came from taxpayers in eastern Canada, a fact that seems to have been

overlooked in more recent years as money from British Columbia and Alberta has gone in the opposite direction and opponents of federalism have become more vocal. In fact, the system did ensure that no province fall too far behind in providing what are considered necessary services up to a certain standard. In any event, federal money enabled Alberta to start some services quite a few years before they would otherwise have been implemented.

The mechanism for obtaining a DNHW grant necessitated an initial application and, after the first year, an annual progress report from the person in charge of the service. The hospital or university had to signify consent to the project, and approval had to be obtained from the appropriate provincial ministry; the latter, at times, required considerable persuasion.

It took a year or more to obtain approval to set up pre-school deafness and cleft-palate clinics. On one occasion I asked UBC's professor of pediatrics and the Deputy Minister of Health from British Columbia to stop over to meet with the Albertan Minister and add their statement of need for such clinics. My exasperation increased during the meeting as the Minister could not, or would not, understand that early diagnosis and comprehensive treatment of an affected child could not be achieved as long as one had to continue relying on the family doctor, possibly a consultant if one was available, and maybe the public-health nurse. For one thing, we tried to explain, the diagnosis of impaired hearing in a child 1 or 2 years of age was most difficult with the instrumentation we then had available; that treatment of a cleft palate had to be started in the neonatal period and required co-ordinated follow-up therapy by, at a minimum, a dentist, an orthodontist, plastic surgeon, ENT specialist and pediatrician; and so on. In the case of deaf people, nerve deafness was still a puzzle to the inexperienced: many of these patients can hear low notes (i.e., vowels) but few of the consonants, and so, we explained, they seem to hear but what they hear is

garbled, and this is reflected in poor speech and failure to master language. In those days, although the parents of many of these children recognized that something was wrong, they could not define it to the doctor: many a child of school age with a label of mental retardation, emotional disturbance, or learning defect, would have been able to cope normally had someone recognized the need for just a hearing aid in the early years, but without it the child could never catch up. And we pointed out the costs, the economic consequences for all, including the Province, if the situation were not remedied. But throughout our meeting, as these examples were put before him, the Minister kept remarking "I don't get it." I suppose my disgust and derision must have shown on my face, because toward the end he said with a smile: "Dr. Martin, you may think me a stupid old duffer, but I still don't get it." He could not have expressed my thoughts more succinctly!

The Department initiated or co-operated with a large number of other community pediatric services beyond the University Hospital, with many pediatricians on staff at our hospital or others giving of their time and expertise. As services for more of the disabilities of childhood were established, there was a danger of their developing into 'disease clubs' scattered around the City and it became obvious that this was a wasteful, somewhat inefficient use of services. Thus it came to pass that the idea for a single center for diagnosis and the care and education of children with permanent disabilities was promoted, through parents' groups, letters to the Premier (Mr Manning was a sympathetic and most perceptive listener), and discussions with ministers and professionals. Admittedly, I had in mind the possibility of this being a component of a children's hospital, in the hope that it might be sited on or close to the University campus, but it became very obvious that such a location would be highly suspect in the eyes of politicians as well as the medical profession. The then Minister of Health disliked the

University Hospital, suspected anyone on full-time staff of the Faculty of Medicine, and specifically had no hesitation indicating to me that I was just out to build an empire!

In all fairness, it should be said that when the Minister realized I was not concerned with having everything in my direct charge or with who got the credit for any new service, we became good friends and I was included in much of the planning for new children's services. Before these halcyon days of my acceptance, however, we had to contrive all sorts of ways to spur things on. A ploy that worked well on several occasions was to prime a group of lay people with facts and figures, outline ways for implementation, and persuade them to tackle the politicians. As these people represented votes, not only were they heard but also the practical possibilities were explored. Some politicians took delight in informing me of the views expressed to them and inferring that, as a supposed leader in my field, I was somewhat slow off the mark! Anyway, by one means or another, development proceeded rapidly.

In 1963 the Glenrose Provincial Hospital was opened in the old Royal Alexandra Hospital building. At first, this accommodation was used for the convalescence and rehabilitation of patients of all ages, thereby freeing active treatment beds in the City's acute care hospitals. In 1964, 46 children's beds were added and space was designated for a centralized facility for comprehensive assessment of handicapped children—including those with cerebral palsy, so the existing clinic was transferred.

I was happy to be invited to participate in this project and to be on the Glenrose Advisory Committee. It was my aim to get a very broad definition of physical handicap, partly to make services more widely available but especially to get away from 'disease clubs'. Insofar as the incidence of impaired intellect and emotional problems is higher among patients who have chronic disabilities than in the general population, it was my hope that the assessment

service would include children who had been labeled retarded, all those who had a physical handicap, and all who were severely emotionally disturbed. Even today, many of the general public and not a few professionals look askance at people who are mentally retarded: to a degree, they are afraid of these harmless people (that is, harmless if dealt with and trained correctly, with just the rare exception). However, the local Association for the Retarded guarded their field of endeavor jealously; therefore, this group of patients was excluded from our care, except for those with borderline or mild retardation who also had physical defects and many of the pre-school children with or without other disabilities whose level of intelligence had not been clearly defined. Child-guidance services under the jurisdiction of the Provincial Mental Health Service were to have separate physical facilities and administration; but, happily, within a short time of the School Hospital's opening, in 1966, services for all the emotionally disturbed and physical handicapped children were integrated under a single clinical director with one administrative structure.

The Glenrose Advisory Committee, of which I was chairman, reported direct to the Minister of Health; it had his unstinted support and, for that matter, the support of other ministers and the Cabinet. The Committee, appointed by the Minister of Health, was rather unusual, consisting mainly of people chosen for their expertise in construction, interior decorating, planning, and so on. It met frequently and soon go onto the task of planning the new school hospital and defining its functions. People cheerfully accepted responsibility for a lot of tasks, and gave their time and effort unstintingly. The facility was built and fully equipped in a matter of 16 months, and when it opened we were proud of having been part of the planning and initiation.

Early in the 1960s I was asked by Dr. Reginald Butler, Director of Health Services for the western Arctic to be a consultant in the

Arctic. Butler was an example of the best type of public servant, not content with sitting behind a desk issuing directives: he studied local problems, and he was knowledgeable about the people he was trying to serve and had a deep respect for them and their way of life. This was before the Arctic was split administratively into east and west. The larger population groups had either a nursing station or small hospital, whose staff were responsible for the surrounding area. The idea was that I would be flown up to a number of these centers from time to time for 10-day trips: at the main centers I would see children with medical ailments that were presenting a problem, and in the smaller units a nurse would give a composite picture of the commonest diseases and the environment and living conditions of the local people. At that time the biggest problems in children were skin infections, diarrhea, and ear infections that in many cases resulted in impaired hearing. Although these conditions could be treated medically, with some degree of success, their prevention was a social problem. I am sure Dr. Butler knew beforehand that I would not be able to contribute much to the latter solution, but maybe it strengthened his hand as well as boosting morale and provide some educational facets to the doctors and nurses.

Within the budgetary limitations, this was a fine medical service with a superb leader. One can imagine the problems in planning to provide services to a population of 10,000 scattered across an area totalling 1.25-million square miles. In the early '60s a few consultants spent time in the North, and by the end of that decade agreement had been reached with every medical faculty in Canada to provide full consulting services to a corresponding area of the Arctic. Also, departments were encouraged to send residents in training for limited periods; in Edmonton, pediatricians were delighted to go on these trips.

Changing Times

Between 1957 and 1971 there were two deans of medicine. When I was first appointed here, in 1957, the incumbent dean was Dr. John Scott, a remarkably knowledgeable man who had spent a considerable time in biochemistry before going into internal medicine. He had a busy practice, his appointment as dean being part-time, and around this time he was about to become the president of the Royal College of Physicians & Surgeons of Canada. John Scott was a very gentle person with a great sense of humor; he once told me that he seldom answered correspondence within 3 months, having found that in most cases the problem had gone away by then!

Dr. Walter C. McKenzie (who later had his family name changed back to Mackenzie), who became Dean in the early 1960s, was a real driver of all departments in the medical school. He judged by results—the success of undergraduates and graduates in their examinations, the number of papers published and presented during the year, grants obtained, and the reputation of each department in the eyes of comparable departments elsewhere in North America and overseas. Any new project that would enhance the reputation of a department, and thus the medical school, he supported whole-heartedly. Having a forceful personality and being a good advocate, he usually obtained what was needed—within the University, from the provincial government, or through external agencies. Thus, the rate of growth speeded up throughout the 1960s and into the '70s. Dr. MacKenzie's aim was to have a first-class faculty, recognized world-wide, and in this he was successful.

The first budget submitted by the Division of Pediatrics, in 1957, was for $21,650; my last, in 1971, was for around $300,000. These figures look small compared with today's, but a good deal of recent increases has been due to soaring costs. As an aside, even in 1971 the writing on the wall was clear; and money was to get progressively tighter.

In 1957 the President of the University of Alberta was Dr. Andrew Stewart; he was followed shortly by Dr. Walter Johns. The Dean, the President, and all the other senior administrators were most supportive once they had approved a project in principle, an attitude that enabled us to make such rapid progress. In fact, of course, there is only one criterion by which a treatment, action, or proposal should be judged: is this in the best interest of the persons for whom it is intended?

The first major upheaval in the undergraduate curriculum, in the late 1950s, was followed by further refinements as the need arose. The next major changes, which involved the entire faculty, were brought in in the early '70s. Throughout, a lot of time was spent on planning the new buildings to facilitate expanding the staff and programs, especially the Faculty's needs in relation to the University Hospital. First (eventually) came the Clinical Sciences Building: it was frustrating to have all plans cancelled, several times, and the only (cynical) amusement that came our way lay in our ability, with each new set of plans, to slip in unnoticed a few-hundred more square feet for the Department of Pediatrics. When completed, the Clinical Sciences Building housed the offices of the expanding full-time staff, common-use examining rooms (which meant we could involve students and residents in private consultations), office staffs and all the research laboratories. The new hospital buildings did not come to fruition until after I had left; one of the facilities I had looked forward to was adequate provision for day-care.

My association with the Department of Pediatrics for nearly 15 years was an exciting, rewarding experience. I was fortunate to work there during a period of unprecendented development and change. Throughout, I enjoyed the support of all those attached to the Department. Bill Taylor—the first full-time staff member—remained a loyal friend and my right-hand man; he provided many of the original ideas for improving teaching and setting up research projects.

Nurses and isolette in neonatal premature nursery, c. 1965.

In conclusion, not so much a part of a history of our department as a tribute to our patients, is my personal appreciation that association with parents and their children was always fulfilling. They kept me humble if ever I began to admire my own skills: either I would realize some foolish oversight or glimpse a more efficacious means of achieving a better solution to the problem. My most grateful patients were rarely those for whom I had done a particularly skilled professional job, but rather those to whom I had but listened or perhaps had given an appropriate word of encouragement or sympathy. They were the ones to whom I had, professionally, contributed least—a sobering thought, but one that may find an echo with others who have have chosen to follow this exacting but fulfilling discipline.

On Being Acting Chairman of the Department

WILLIAM C. TAYLOR, MB, ChB, DCH, FRCPC
Acting Chairman, Department of Pediatrics, 1968–1969

I had known Ken Martin for about 5 years in Winnipeg before I arrived in Edmonton. For the first year I had been the chief pediatric resident at the Winnipeg Children's Hospital, and there I had the chance to observe Ken at work and at play. At work he was a forceful, astute clinician, with a particular interest in neurology, a subject he still pursues in retirement. At play he could be the life and soul of the party—among the first to arrive and the last to leave—and was a formidable opponent in the many memorable games of strip poker among residents, nurses, and interns.

Dr. William C. Taylor

Our most (in)famous party was a Burns' Night supper I had organized in the old interns' quarters, complete with military pipe band, haggis, and highland dancing. Now the haggis was cooked in the basement, on a hot plate in Bruce Chown's Rh laboratory, and during the evening the electrical fuses blew; this placed the freezers, in which Dr.

Chown's valuable sera were stored, in great jeopardy. Dr. Chown arrived when the debauchery was at its height, with drunken pipers and half-eaten haggis strewn around. Taking this remarkable scene in at a glance, Dr. Chown quickly and quietly replaced the fuses, thus saving his sera. (Great gentleman that he was, Dr. Chown never mentioned this incident until, many years later, he published a reminiscence of his years in Winnipeg.) Meanwhile, Ken and I, blissfully unaware of the drama being enacted under our feet, carried on partying. At 7 a.m., the pipe band was forcefully ejected into a freezing January morning, still wearing the kilt and with only just enough money to pay the street-car fare back to their barracks.

Ken had confided in me his plans for coming to Edmonton, and I begged him to find a place for me; this he very kindly did, with the result that in 1957 I became the second full-time member of what was then the Division of Pediatrics. Ken, who was a skilled poker player, kept his planning cards close to his chest, but he divulged sufficient of his long-range plans so that I could appreciate the direction in which he wished Pediatrics to move. Thus, in June 1968, when he took his sabbatical leave and I was appointed acting chairman, I knew what had to be done in terms of long-range planning. My main aims in that position were to consolidate the gains Ken Martin had worked so hard to achieve, to pursue whatever long-term objectives he had in the making, and to return the Department in as good a state as possible after my one year's stewardship. In my first week on the job I learned what Ken had accepted many years before, that most people coming to a chairman's office want something, or wish to complain, or both. Thus, at the end of the year, when some of the staff complained that I had not initiated enough change I took it with a grain of salt, reflecting that I had at least maintained the Department intact.

One fact of life I was well aware of was that I would have to deal with Dean Walter Mackenzie. Now, many wonderful eulogies have

been written about the great man, and many of them are true, but when working with him every day from the insecure footing of an acting chairman I found him to be a ruthless tyrant. In my early medical training in Scotland and England I had encountered many 'great men': all were forceful characters, some were eccentrics, and some were petty tyrants, but I had never come up against anyone as awesome as Walter Mackenzie especially when he was enraged. I knew he had a kind side, as when he performed a bowel resection on my 72-year-old mother: he visited her twice a day for the first week after the operation, sometimes holding her hand and chatting to her for 20 minutes at a time. My mother worshipped him, and for his kindness to her I held him in great respect.

But working with Dean Mackenzie, on an academic or administrative basis, was something entirely different from social or medical contacts. A good example was a meeting I had with him in July 1968; I recorded the events at the time,.and quote them here in their entirety to give the atmosphere of what it was like to deal with this extraordinary man.

> **Wednesday, 3 July 1968, 3 p.m.:**
> Presented the preliminary budget estimates for 1969–70 to the Dean in his office. This experience was rather like having a conversation with an electronic computer. No friendly greeting and never a word of goodbye. Just straight to work and a ruthless elimination of any items in the budget directly relating to research.
>
> Peter Bowen's $10,000 of equipment - Rejected.
> Peter Bowen's $3,000/annum salary for a dish washer - Rejected.
> Al Stewart's half time technician - Rejected.

> Yet all sorts of piddling little things, like teaching aids, teaching fellows' travel, travel for genetic patients, laboratory supplies and sundries were all approved. The Dean believes that any and ALL research activity must be supported by research funds and not by University money. A strange philosophy which Ken has not explained to me, when half the activity of the Department has to do with research and half has to do with teaching or learning. I suspect a new half has been added, and that is administration, which keeps everyone above the rank of assistant professor very occupied indeed.
>
> NEVER WASTE THE DEAN'S TIME. NEVER GO TO HIM WITHOUT ASCERTAINING ALL THE FACTS. NEVER EXPECT HIM TO HELP WITHOUT A STRUGGLE. This man is power hungry and a despot.

I was out of the office 10 minutes later, shaking with concealed rage.

On 7th January 1969, a fracas arose over a complaint lodged by the chief of the pediatric service at Hospital 'X'. Because of the shortage of residents, for 2 years we had been unable to supply Hospital X with a pediatric resident; and at the end of 1968, in the rush of Christmas activities I had forgotten to notify Dr. B. that for the third year running Hospital X would not have a pediatric resident. It so happened that Dr. B. was a fishing and hunting partner of the Dean, and he telephoned his friend Walter direct.

"Dean Mackenzie phoned me up in high dudgeon", I recorded in my notes, "demanding my presence in his office immediately." I headed up the 13 flights of stairs to his office, as this would give me sufficient time to think up a possible excuse, and arrived all hot and sweaty. He immediately launched into an indignant tirade, asking

why I was so discourteous to a practising pediatrician. Without waiting for my breathless reply, he demanded that I immediately provide him with a written apology that he could send to Dr. B. As it was now 17:30 hours, I asked if I could have it on his desk at 9 a.m.; reluctantly he consented. Like the good obedient chap I am I drafted a letter—explanatory, apologetic, ingratiating —for the Dean to send to Dr. B. In addition, I drafted another letter which I sent under separate cover to the Dean, pointing out the complete lack of effort on the part of the pediatric teaching staff at Hospital X. I believe the Dean got the message, as there were no further difficulties with Hospital X.

The great excitement in my year of office was the move into the Clinical Sciences Building, when on the 8th of April, 1969, the Department of Pediatrics moved into offices on the fourth floor and part of the fifth. This day coincided with the visitation of the AAMC/CAMC accreditation team, who wished to survey the entire operation of the medical school. Everyone was in a lousy mood, and departmental members (including my sister, Dr. Jean Nelson) came clamoring through my door complaining of the inadequacies of their own space and equipment. We had worked so hard for years, poring over blueprints, preparing lists of essential equipment, and deciding who should have what space, that when the move came coincident with the accreditation team's visit the lid blew off the kettle. At the time I was reading Arey's book, Territorial Imperative, which among many other interesting biological observations describes how the humble little stickleback fish stakes out its territory on the bottom of the pond and tenaciously defends that territory even unto death. I was observing such behavior in the members of our department.

There was one refreshing episode during the move into the new building, when I was asked to approve the furniture, decoration, and color co-ordination of the chairman's office. This was the only office

to be awarded such luxury—all the others had standard-issue furniture. I chose dark mahogany furniture, a rich green carpet, and thick textured drapes with a dark floral pattern. The fittings, when they arrived, looked restful and rather luxurious, just as the consultant in interior design had said they would. I enjoyed that office, wistfully dreaming of the day when it might be mine. The dream lasted for just 2 months, until the rightful owner returned.

As this history is being written, that lovely office stands empty. But before the beautiful office was finished, while the troops were still mutinous over the disruption of the move into the Clinical Sciences Building, I arranged for a champagne party to start at 3 p.m. on the second Friday. The celebration continued until 7 p.m. and all the champagne had gone; after this, even my sister was ecstatic with her new quarters and I had very few further complaints about space from the Department members.

In December 1968 I arranged a successful and cheery farewell for Al Stewart, our full-time pediatric biochemist, who was leaving to take up an appointment at the newly built Isaac Walton Killam Hospital for Children, in Halifax, Nova Scotia. Much less successful was the staff's 1969 Christmas party I arranged at the Faculty Club, to which the medical staff, nurses, interns and residents were invited. I had great difficulty getting general agreement from the attending staff, especially those whose main affiliation was at a hospital other than the University Hospital, but finally the night of 9th December was chosen. Ten staff members and two residents turned up at the appointed hour, soon to be swamped by 120 nurses, ward aides, desk clerks, and Peter Bowen's dishwasher (who had been saved from Dean Mackenzie's slashing). That the evening was saved was due entirely to Brock Armstrong's heroic piano-playing. The cost of the party was $420, and as three of my colleagues refused to pay I was obliged to pay the balance out of my own pocket. When the dust had settled I resolved to never again become

involved in organizing a Christmas party for staff, a resolve I have kept to this day.

In June 1968 I became involved with the affairs of the recently formed Institute for Research into Mental Retardation. This remarkable organization was spawned out of the Department of Educational Psychology by Don Cameron, supported by an advisory committee whose members included Don Campbell (biochemistry), Peter Bowen (genetics), George Monckton (neurology), and Walter Worth (academic vice-president). The Institute was funded by the Canadian Association for Mental Retardation in the sum of $250,000, which was to be spread over several years and to include salary for a medical research fellow with interests in this field. Ken Martin had agreed that he would support a joint appointment with the Department of Pediatrics, which would contribute $4000 annually toward the salary. I helped to interview a few applicants for the job, but did not consider any of them suitable until a bright star from the eastern USA turned up. This was Ernie McCoy, who at that time was professor of pediatric research at the University of Virginia, in Charlottesville.

Ernie McCoy was a graduate of the University of Alberta, had been a Markle Scholar in Medical Science, and had received two Research Career Development Awards from the US Public Health Service. He had done most of his postgraduate training in the USA, starting with residency and a research fellowship in St Louis before returning to Canada in the '50s to become the first pediatric specialist at Burnaby General Hospital as well as clinical instructor in pediatrics at the University of British Columbia. A few years later he went back south of the border, to work at Vanderbilt University, then the University of Missouri, and finally the University of Virginia, where he was appointed professor of pediatrics in 1967.

Dr. McCoy had published extensively on the subject of biochemical change in children with Down's syndrome and was

highly regarded throughout pediatric research. Because of these impressive credentials Walter Mackenzie brushed me aside: he felt this was such an important fish to land he should conduct the negotiations with Ernie himself. The proposal from Dean Mackenzie was that Ernie might serve as a replacement for Al Stewart and would be appointed professor of pediatric research. When Ernie McCoy chugged up to the University Hospital in September 1968, driving his little 1966 SAAB, I was there to greet him. Immediately, I was struck by his warm and friendly manner, which was very different from that of the high powered research types I had interviewed earlier.

The negotiations continued for 3 months, while Ernie spelled out his needs very clearly; these included $65,000-worth of laboratory equipment, plus a fully equipped clinical metabolic unit, for a total cost of just over $100,000. The Dean warmed to the task of dealing with these sizeable sums of money and tried hard to meet all of Ernie's requests. After several phone calls and two more personal visits, Ernie agreed to return to his alma mater; he took up his appointment early in 1970, and took over chairmanship of the Department of Pediatrics 18 months later.

In the academic/administrative field it was my pleasure to welcome the new pediatric residents to our training program. In 1968 these included Drs Lord, Gokiert, Co, Kass, Rouget, Easton, Popowich and Wu, who arrived on the scene around the 1st of July. I also helped two of our past residents to obtain grants that would further their careers: Henry Pabst secured a Heart Foundation grant for studying immunology at Minnesota, and Adrian Jones received a Mead Johnson fellowship to study gastroenterology at The Hospital for Sick Children, in Toronto. Both subsequently joined the academic staff as full-time members.

During my year in office I was lucky enough to experience a 3-week mail strike! This brief respite dried up the flow of mail that

crossed my desk. I also sought out ways to relieve tension, the most satisfying of which was to start work on my first book, a biography of J. Norman Collie, a Scottish mountaineer of great distinction who made many first ascents in the Canadian Rockies. About half this manuscript was drafted in longhand while I sat through what, up till then, had been interminable hours of boredom—meetings of the General Faculty Council—and thus was able to work creatively and at the same time keep an eye and ear on any matters that might affect the Faculty of Medicine.

On the 2nd of July, 1969, Ken Martin returned. My feeling of relief was enormous, but on the whole I had enjoyed the year with its many interesting challenges. Some time after the dust had settled, Tim Cameron, the Associate Dean of Medicine, came up to me in the corridor one day: "Bill! I just want to say thank-you for looking after the Department for 1 year. Probably no one else will thank you (they didn't) but I think you have done a good job." That was reward enough.

Chapter 3

The 1970s: The Flowering of Pediatric Research in Alberta

ERNEST E. McCOY, MD, FRCPC

Chairman of the Department of Pediatrics, 1971–84

Upon my appointment by Ken Martin at the beginning of 1970, I spent most of my time organizing the research laboratory and arranging to have access to patients on whom to conduct our research. Also, I took over directorship of the Institute for Research into Mental Retardation (a post I relinquished when I became chairman of the Department), and worked with Ken to establish the Clinical Investigation Unit, which I felt was sorely needed, and became director of it.

The first priority I set on assuming chairmanship of Pediatrics was to expand the number of pediatric subspecialists. At that time, Peter Bowen was in genetics, and Adrian Jones and Henry Pabst, in gastroenterology and immunology respectively, had just arrived back. We had, in addition, Bill Taylor and Lois Stayura at the University, Peter Wilcock half-time at the Camsell, and George Eddy at the Royal Alexandra. Despite the wish to expand the subspecialties within the Department, we were even at that time faced with a financial squeeze and there was no money for new positions. When Lois resigned, this provided a full-time salary, with which we

Dr. E. E. McCoy

recruited David Schiff, the first full-time neonatologist. (It is interesting that, at that time, several members of the hospital staff raised the question whether we really needed a full-time neonatologist.) It took only a few months for David to re-organize the nursery; we were able to acquire a considerable amount of equipment and upgrade the area, and it was not long before people accepted the change and appreciated the improved standard of care.

With this improvement in service came the realization that we needed to establish an intensive-care center for neonates. The Hospitals Commission was willing to fund this, and with a full-time staff member at the University Hospital this seemed the logical place. However, a very strong argument was put forward that the four- to five-thousand deliveries a year at the Royal Alexandra Hospital warranted a neonatal intensive-care unit there, too. Proposals were put in by both institutions to the Hospitals Commission, and Dr. Jack Bradley, Chairman of the Commission, convened a meeting which was attended by representatives of both the Royal Alexandra and University Hospitals. This was one of the hottest encounters of its kind I endured over the years, and it ended in a stalemate. Mr. Brunell, who at that time was working in the Provincial Department of Hospitals, came to work with me and over a period of several months we worked out the rationale and justification for establishing not one but two units in the City. The unit at the Royal Alexandra Hospital was to look after predominantly the babies born in that institution, and the University Hospital would look after high-risk infants from there and all who were.referred from peripheral areas of the northern part of the Province. Along with the regional program for high-risk neonates, a high-risk obstetrical program was established in both institutions; but, sadly, the latter program never really got off the ground at the University Hospital. By contrast, the neonatology programs in both institutions are among the best in Canada. After this, we were able

to recruit Neil Finer, who had finished his training in Boston and has played a dynamic creative role in establishment of the unit at the Royal Alex.

With Lois Stayura's retirement on her marriage, we needed someone to look after our clinic for ambulatory pediatric patients. For this we took the part-time salary (from the University) that became available, and a half-salary from the Northern Nurse-Practitioner Training Program that we had worked hard in implementing, to provide a full salary for Sue Miller, who did an excellent job in both positions. Incidentally, the clinic for the ambulatory patients was established originally with Lois Stayura's private patients, who until then had attended the Health Sciences Clinic; it was continued by Sue and has grown steadily over the years.

The second subspecialty in which we recruited was hematology-oncology. Dr. John Akabutu had finished his training in Cincinnati and came to head up this service, and since then has expanded it into a model program.

The success of the regional program in neonatology, with the recognition by the provincial government of the contribution it was making, led to the introduction of other regional programs. In all of these we stipulated that, although the money for salaries came through the Department of Hospitals, the main appointment was to be to the University—not the Hospital; thus, the stipend was funded to the Hospital and thence to the University.

This arrangement, I feel, worked extremely well and allowed us to increase the number of staff in the Department in a time of continued restraint for funding of new positions through the University. We made a submission for a regional program of pediatric cardiology, which met with the approval of the Minister of Health and enabled us to acquire salaries for three cardiologists. Similarly, we managed to establish a regional genetics program,

which allowed us to recruit two additional geneticists as well as a cadre of support staff; and, working through the Cross Cancer Institute, Dr. Akabutu and I established a regional program for pediatric oncology, funded predominantly through the Institute. Also, Pediatrics obtained money for a regional hemophilia program.

Another main objective was to utilize the facilities at the Glenrose Hospital; for this purpose we obtained financial support for Charlene Robertson to undertake long-term studies of survivors from neonatal intensive-care units. The clinical arms of the Department having thus been strengthened substantially, it became evident that another critical area needing attention was intensive care of children beyond the neonatal period. We persuaded the provincial government to fund this special program and were lucky enough to recruit Dr. Robert Katz to that position, which he held for 2 years; he then returned to Albuquerque.

Along with this build-up of the subspecialties, we added pediatric positions at the Charles Camsell, Misericordia, and Royal Alexandra Hospitals. After Peter Wilcock's death, the teaching program was managed for a time by Dave Wilkinson along with Ed Burchak. After Ed left, Dave carried on alone; but then he, too, left, to go to British Columbia. We thus had a salary available, and with this we were able to recruit John Godel. John held the fort alone at the Camsell for 2 years, but the task grew so much as to be overwhelming for one person, so I approached the administrator of the Hospital. This happened to coincide with the Camsell's transition from federal to provincial governance, so I delivered an ultimatum: either they provided two more salaries right away or one salary now and two later, or we would pull Pediatrics out of the Camsell entirely!

We were fortunate that the Royal Alex did fund two positions. We recruited for them then—and, later, both were transferred (as full-time positions) to the Department through the University. At

the Misericordia, I could now fund Dr. Charles Fried part-time, although he continued to work work full-time at the job. After Charley's death, it was some time before we could work out arrangements for Dr. Paul Taylor to be funded through the Misericordia Hospital as director of the neonatology unit. Charley made a tremendous contribution to undergraduate teaching, out of all proportion to any remuneration he ever received. At the Royal Alexandra Hospital, we supported Dr. Gauk with monies from sundry programs, initially through the contract with the Eric Cormack Center, to establish a full-time position.

In all of these efforts, not one full-time position was granted us by the University: we always had to start with part-funding from non-University sources and gradually acquire more funds to make each into a full-time University position. This had its drawbacks for recruitment but allowed us to build a strong clinical faculty.

As professor of pediatric research at the University of Virginia, I had had a well-equipped laboratory, sufficient research grants, and a training program. When Dr. MacKenzie asked me to return, I said I would on condition there was an equally well-equipped laboratory here. He and Ken Martin were able to come up with the necessary funds, although in later years he said it almost broke his bank to have the equipment in place. Much of this equipment is still in use in the Department, including the ultracentrifuge; but the original liquid-scintillation counter, aminoacid analyzer, and gas chromatography machines wore out and had to be replaced. Funding for research is harder to come by in Canada than in the USA, the expenditure per capita being much higher in the latter, in a ratio 3 or 4 to 1. Despite this, however, all of our Pediatrics research funding has been maintained until the present.

Funds obtained from non-university sources were used mainly to recruit clinicians, with the aim of establishing clinician-researchers. Some of the people who came into the regional

programs started to do research, but their clinical loads were so heavy that for most their research activities became minimal. There were a few exceptions, but these people had to expend superhuman effort to be productive researchers.

In 1973 Dr. MacKenzie asked me to be Alberta's representative on the Medical Research Council. I accepted the position as I felt it important that a clinician represent our Faculty on that body and that being on the MRC would provide useful information in relation to the Department's growth in research. After 2 years on the Council, I joined the executive of the MRC. It was there that the seeds were sown for a proposal to establish the Alberta Heritage Foundation for Medical Research; also, I learned the intricacies of the Development Grant Program—and a Development Grant in Nutrition was obtained, with Dr. Spady as the principal investigator. This is another example of how new positions were created.

When Malcolm Brown was President of the Medical Research Council of Canada, I remember him saying: "Well, maybe Alberta shouldn't be eligible for development grants, because of the amount of money you have." This was at a time when we had very few researchers, both in most of the basic sciences and in all of the clinical departments, in comparison with schools such as Manitoba, Toronto, and McGill, and particularly McMaster. Both Keith McCannel, from Calgary (who also was on the executive), and I were incensed at this; and later, back at the hotel, we decided to propose to our respective Deans that our two universities work out a joint proposal to put to the Government of Alberta for the establishment of a medical research foundation. The time was right, Premier Lougheed having indicated that this was one of his priorities. I won't go into extensive details, but I chaired the committee, wrote the proposal, and was responsible for preparing most of the final document that went to the Government. This has had a tremendous effect on the Department; in fact, I count it as probably the best contribution I made to our medical school overall.

During my time as chairman of our department I acted in an advisory capacity for various organizations and foundations, including membership on the Ad Hoc Advisory Committee of the Heritage Foundation, chairman of the Canadian Pediatric Heads of Departments, a member of the executive of the Canadian Pediatric Society and Chairman of the Canadian Cystic Fibrosis Foundation. I also served on the Advisory Committee of the Research Institute of The Hospital for Sick Children, an appointment I accepted in order to gain insight into the Institute's workings—because, in my mind, I was forming the idea of a pediatric research institute here, and I wanted to have a very close look into the Institute as a model for our own. Contacts made during this period proved invaluable later and have greatly benefitted the Department.

I attempted recruitment of a number of people in the early years the Heritage Program was available, particularly for the Neonatal Pharmacology Program we were hoping to establish, but we encountered insurmountable problems relating to space for researchers and cross-appointments with other departments. Perhaps the biggest shortcoming of my actions was the time I spent on the Cavanagh Commission. Had I devoted that time instead to recruiting staff for the Department, this would be in a much stronger position today. I accepted the work on the Commission as fulfilling an obligation to the children of Alberta, never realizing the vast amount of time it would take away from the Department. Although I am proud of the Commission's work, I regret very much the consequences for the Department.

During most of the time I was Chairman, Tim Cameron was Dean of Medicine; he followed Walter MacKenzie, with whom I had excellent relations—although reluctant to give on any point, he was always supportive of good endeavors if the cost was minimal. The thing about Tim Cameron was that he would always try to help. He used to say: "I hate to see you come in because you're going to nickel and dime me to death." By that he meant I always came up with

part of a salary and ask him for a small amount that he knew very well he would have to increase as the years went by. Tim was responsible for switching some of the appointments from Hospital to University funding; he realized that, sooner or later, the money coming from the Hospitals Departmental Fund for salaries of faculty members would cause problems, but this was the only way we had of adding staff. In regard to the University Hospital, John Read was extremely helpful in most instances: through him, we managed to pay salaries of staff who operated the regional programs based at the Hospital. Inevitably, there were differences of opinion at times, but these could be resolved through tough bargaining, and overall he was very supportive of the Department's growth.

In the early 1970s, Pediatrics was not considered equal to the so-called 'major' departments of Medicine and Surgery. I can remember the fight to achieve full membership on the Medical Staff Advisory Board, a fight that lasted at least 6 to 8 years. For only 2 of those years were we voting members. I'm afraid my wrath surfaced many times in discussing this inequity.

The Walter C. Mackenzie Health Sciences Centre

The biggest difficulty I ever experienced was in relation to the number of beds in the new Mackenzie Centre. Ninety beds were allocated to the Department—at a time when we were fully utilizing 114 in the main section, an additional 4 on Station 34 (obtained in exchange for beds for children with infectious diseases on what had become the clinical investigation unit), plus 2 in the ICU and 1 or 2 in the cardiac ICU. When we negotiated for the establishment of a 6-bed pediatric ICU, initially we agreed to have 4–6 beds in the General Systems Failure ICU, but when Robert Katz was here it became evident that this would not be a feasible arrangement. Later, the Hospital's administration forced on me the alternative of no pediatric ICU or its incorporation within the allotment of 90 beds, and finally it decreed no option whatsoever: the Pediatric ICU would be part of the 90-bed allocation to go in that area. I still consider this decision high-handed and unjust, in comparison with allocations to other departments and, even worse, one that took no account of the often rapid development of serious illness in children. There should be at least six more beds in the Pediatrics complement, and I hope the new chairman will fight for this.

The continuing growth of the Department made it inevitable that in time the limited space available in the Clinical Sciences Building would necessitate our spreading into other locations within the health sciences complex. In fact, by the time we moved into the Mackenzie Centre, pediatric cardiology was in the old neonatal ICU, the Pediatric Clinic was on the first and genetics was on the second floor of the Nurses' Residence, and most of the oncology program

was at the Cross Cancer Institute. Departmental administration was cramped almost to the point of absurdity; for example, the (small) pediatrics library had to serve also as 'offices' for graduate students and part-time staff, conference room, and occasionally lecture room. Thus, when we were selected to be the first clinical department in the Mackenzie Centre we thought we deserved it!

It had been decided in discussions during 1981–82 to consolidate the Department into one working unit; however, the amount of space to be allocated was an entirely different matter. In 1976 the Department had been allocated 9000 net sq.ft for all of its clinical and academic activities, an area equivalent to the whole of the academic, clinical, and research space we then occupied in the Clinical Sciences Building—before the major increase in academic staff through the required programs. Despite many presentations for additional space to accommodate the vastly expanded activities, the powers that be held fast to the 1976 allocation—an area roughly equal to the space allotted to the Division of Cardiology of the Department of Medicine! This is the background for our present space predicament.

The planning committee brought in an endless chain of architects, supposedly to assist us in planning our area. Each usually lasted a few months and then disappeared, with little continuity. I remember particularly one meeting with a cigar-smoking architect from Toronto who 'knew it all', wouldn't listen to us, and paid no heed to demonstrated requirements for a pediatric service. Frustrated beyond measure, I told the project chief we would not attend another meeting with him. Subsequently we obtained the services of a Vancouver architect, who listened and was very helpful in implementing our ideas; Adrian Jones headed the committee responsible for planning the inpatient beds. Again, I had hoped this would be only a temporary move, and that Pediatrics would eventually be in the proposed Children's Hospital.

The Northern Alberta Children's Hospital Foundation and Institute for Pediatric Research

A few facts are in order concerning the establishment of the Northern Alberta Children's Hospital Foundation and working toward founding a pediatric research institute.

It should not be forgotten that the Department played a leading role in early efforts to establish the Children's Hospital Foundation. We gathered in Neil Duncan's home one night in April 1978, with Neil, Henry Pabst, Sam Cox, Rob Graesser (a lawyer) and a Mrs Dimmer, whose son was ill. Out of those discussions came the idea to incorporate the Foundation.

One of the first problems was our difficulty in being recognized as a Foundation pressing for the rights of children, not simply a political lobbying agency for the establishment of a hospital. I met with Mr. David Russell, who had been appointed a few months earlier as the Minister for Hospitals and Medical Care. In the first place, he could not understand the special needs of infants and small children and therefore could not appreciate the need for special facilities. We could not convince him, despite our marshalling cogent reasons for centralization—to maximize the benefit of expensive services and apply limited resources in a pattern that avoided duplication. All he could do was to comment: "You already have 500 beds. What do you need any more for?"—choosing to ignore our repeated statement that we proposed closing those beds. Even in those early times, the battle to have the Children's Hospital at the Royal Alexandra vs the University Hospital was becoming apparent, and the Government used this split, along with some family practitioners' hostility to the concept, to avoid making a

decision. From what became apparent later, I think we criticized Mr. Russell unfairly, as it was probably the Premier who was against the concept.

With the arrival of Patty and Peter Horsfield in town, there was a dramatic change in the way and the intensity with which the Children's Hospital Foundation went to the public for support. The Horsfields had two daughters with congenital adrenohyperplasia whom I looked after, and Mrs Horsfield was appalled at the conditions for medical care here in comparison with Toronto. I asked her to be with me on a 'talk show' with Ron Collister shortly after her arrival, and on that occasion she let it be known in no uncertain terms what she thought of the situation here.

Patty and Peter Horsfield joined in our hopes and dreams and plans for the care of children, and Peter became president of the Foundation. They worked long, spirited hours, spreading the word about the Foundation throughout northern Alberta—its present status there is due largely to their efforts—and set in motion a series of shows, telethons, and other fund-raising activities. In the early years of the Foundation, our department was the hub for its organization. Several staff members were on its board and, after working hours, groups of volunteers used the space for stuffing, mailing, telephoning, and the like, and as meeting places; indeed, many of the meetings were held in Room 5-104, and formal meetings, including the Annual General Meeting, were held in 2-115 or 2-117 in the Clinical Sciences Building.

As the Foundation grew, it became more appropriate for board members who were not associated with the Department to take over; this we took as the sign of a healthy organization. But the early efforts were necessary to build a base: the Foundation's present position is the outcome of years of hard work by very many volunteers.

A word about outside experts and the advice they gave on the proposed children's hospital. One of the first of the visiting experts was Harry Bain, whom we brought in from Toronto; he had been physician-in-chief at The Hospital for Sick Children there. Harry met with a number of people and was the first to propose establishment of a children's hospital, and closure of pediatric beds in the general hospitals, in Edmonton. Thinking primarily of the needs of the children and their families, he envisaged a lean but top-notch service for the northern part of Alberta and contiguous areas in British Columbia, the Northwest Territories, and Saskatchewan. Dr. Bain's report met with such an outcry that a lot of his recommendations were forgotten, but he did do an invaluable service: coming from the outside, he was able to focus attention on children's needs in a way we had never been able to accomplish (a prophet is not known in his own country!).

The next expert was Dr. Medovy, from Winnipeg, whose visit also was sponsored by the Foundation. Though his survey was not as extensive as Harry Bain's, he made essentially the same type of recommendations. Reactions were the same but somewhat less vociferous.

The next report, which was commissioned by the Department of Hospitals, was done by a Mr. Goldstein, a hospital planner. Mr. Goldstein took advice on whom to talk to from Mr. Casey, president at the Royal Alexandra Hospital. He talked to a lot of local people, but virtually none from the Department, as well as a large number from eastern Canada, nearly all of whom had never participated in the care of children in a medical facility. In perhaps the worst report in any category that I have ever seen, the man came up with a recommendation for a Children's Hospital, to be located (as was probably to be expected) at the Royal Alexandra.

The last report, conducted by Dick Goldbloom and Pierre Beaudry, which was short, succinct, hard-hitting and to the point,

laid out the facts and requirements, pointing out the need so clearly that it looked as if we would finally achieve our dream of a Children's Hospital. They also pointed out, correctly I believe: "Get the approval first and worry about the site second." As they said, satisfying the need was the more important: always put the horse before the cart!

In view of all the delays and the increasing lag in our ability to advance pediatric services, the Foundation then adopted as its first objective the establishment of a pediatric research institute. This would require less capital outlay for buildings and could build on the research base already in place.

This has to be taken in the context of what was happening in the early '80s, when it was evident that the Heritage Foundation would be a major force in future research in Alberta. Construction of the Mackenzie Centre was in progress. Pediatrics had a total of 6000 sq.ft of research space in the Clinical Sciences Building, and there was no likelihood of any more becoming available; moving to the Mackenzie Centre would free only about 4000 sq.ft of research space in the CSB, and we were not very likely to be given access to that. Furthermore, we would have no opportunity to emulate the University of Calgary's capitalizing on Heritage monies to recruit scholars.

The second component in the equation related to the Foundation's efforts to convince the Government of Alberta of the need for a Northern Alberta Children's Hospital, to serve regions of the Province beyond the catchment area of the children's hospital in Calgary. Before the 1982 election, the provincial government had said "Yes," indicating willingness to consider building a children's hospital in Edmonton to service the northern region, but right after the election they said this was not a high priority and that providing 'chronic beds' was more pressing. It seemed we would never get approval from them.

To keep the issue alive, we then asked the board of the Foundation to consider as its first objective the establishment of an institute for pediatric research. The board agreed, considering it as Phase I of a children's hospital, and meanwhile pressing forward with building up our finances. In fact, a considerable amount of money was being collected, through telethons and general donations—and a large amount from the raffle of a house donated by the construction workers of northern Alberta (who had no political or medical axe to grind and thus an unclouded appreciation of their children's medical needs).

The idea was to use the interminable delay to build a facility for multidisciplinary groups of scientists to work on problems of child health. I proposed that the Institute be built on University land, allowing space for researchers from other departments and faculties to join with those from the Faculty of Medicine, to be close to the University Hospital and thus able to use the same staff, conduct clinical research, and apply the results and bring benefit faster. The University approved of the project and the reasoning behind the suggested location, and designated a parcel of land to be put aside for the Institute. At first this was the site now occupied by the Red Cross Blood Transfusion Center; when negotiations started for the latter building, the site of the Institute was changed to a parcel (at present, tennis courts) on 114th Street, directly across from the Mackenzie Centre. This has now been incorporated into the proposed 'research park' to the south of the building still called the Nurses' Residence.

During 1983–'84 we went through the exercise of obtaining formal approval via University channels for the establishment of an institute for pediatric research. Deans of the faculties of Physical Education & Recreation, Dentistry, Pharmacy & Pharmaceutical Sciences, Physical Rehabilitation and Nursing all supported the concept. After numerous meetings, all the necessary University committees stated approval and in mid 1984 the Board of Governors

gave its final approval. And then, in 1983, two other unrelated important events occurred. One was the transfer to the Faculty of the Alberta Research Council's building when that body moved out; the second was the new plan by the AHFMR. to finance buildings for medical research at both universities, in Edmonton and Calgary. To some degree this has reduced the pressure for research space. However, because of the unexpectedly enormous advances in research in recent years, the amount of space provided has not kept pace with the amount required; everywhere one hears complaints of crowding and of having to split off some activities into other areas.

Furthermore, I am still of the firm belief that a children's hospital with its own research institute, with the two components physically intertwined—as in Toronto, Cincinnati, and elsewhere—can provide the best pediatric care and preventive measures throughout the community it serves. Infants and children are not and never will be simply small versions of adults; I believe we should continue to press for the best possible facilities for them, the best suited to their needs.

A convalescent premature baby c. 1975.

Building Continues: Recruitment and Funding

In dealing with the staff of the Department, I always felt they were mature, self-motivated individuals, people who worked and operated through academic ideals. The raison d'être in a clinical department such as ours is to provide service, and a university brings the added requirement for teaching ability; but it is not a common attribute to possess both clinical acumen and the ability to communicate this as well as having expertise in research. Even so, some administrations still seem to think that all members of a faculty of medicine should be excellent as providers of care and teachers and researchers.

The Department of Pediatrics has been criticized repeatedly for not having sufficient researchers, despite our success in recruiting a large number of present faculty members against what appeared at times to be insuperable financial odds. Now, however, with shrinking sources of money from governments, except in the case of retirements the University is unlikely to be able to fund more appointments. We shall therefore need to build endowment funds for chairs oriented to specific disease as well as general pediatrics.

Dr. Kay Swallow's donation of her collection of paintings, for sale to establish a scholarship, was a big moment for our department, and I hope that others will recognize this and emulate her example. I always hated the lack of a clear, definable image for our department, a lack that stood in the way of our raising money for these ends, and I hope the establishment of the Children's Hospital and Research Institute will enable us to acquire funds in this way in future. Granting agencies such as the Alberta Heritage Foundation for Medical Research can do only so much; endowment funds are much needed.

ACKNOWLEDGEMENTS

Dr. Taylor asked me to comment on how I kept my sanity during the time when so many balls were bouncing. I can only say that is was because of a wonderful wife, who supported me throughout all this turbulent period and developed her own accomplishments in tailoring and painting as well as being 'the hostess with the mostest' for innumerable dinners and many parties.

Of course, as for any other undertaking, building the Department was a joint effort, not possible unaided. Doubtless there are many things I have forgotten or missed out on this review of the growth of the Department over the past 14 years—I am counting on members of the Department to embellish and otherwise state their views (as they have always done, in no uncertain terms!) of how, in fact, things went.

One leaves the most important point to the last, to thank all who made the job enjoyable and challenging. To you in the daily practice of pediatrics who have contributed so much over the years, I wish I had dollars to give equal to my thanks to you...to Henry Past, John Akabutu, Adrian Jones, Elizabeth Ives and Paul Taylor, thanks for your hard work in the residency program; and to Bill Taylor and the heads of Pediatrics at the hospitals, for work in the undergraduate program, many thanks. Thanks also to the members of the regional programs, who have labored hard to improve the health care of children in northern Alberta. Finally, thanks to Frances Harley for taking on the chair and doing a more-than-excellent job, and to the unsung helpers in the background—Margo Langer and Colette Ethier—who did most of the work. Together, we have grown and achieved; and if you seize future opportunities for growth and achievement (and I know you are not ones to let opportunities pass you by), you will make the past achievements pale by comparison.

Chapter 4

Anecdotes and Personal Memories of the Acting Chairmanship of Pediatrics, 1984-1986

FRANCES L. HARLEY, MD, FRCPC

Writing my memoirs of the 2 years of the Acting Chairmanship seems to have had the same effect on me as if I had been asked to study in the library after taking the Royal College examinations. The quantity of dictation, writing, revision and reading that suddenly descended upon me in the Chairman's office was overwhelming. The antipathy I have developed to mail and dictation has left me with great difficulty in reading anything longer than 2 minutes and the habit of not opening my own mail at home more than once a month.

I recall the late afternoon in April 1984 when Ernie McCoy dropped into my office saying he was planning to take a sabbatical year at the NIH, and, having already unsuccessfully approached two other members of the Department to take over the acting chairmanship for the year of his absence, was coming to me because "you are next in line." I was frankly appalled at the idea, because I felt I was already fully employed and couldn't conceive of how I could fit this little job into my schedule. I soon learned that you add at least an hour at the beginning of the day, an hour and a half at the end of your established schedule and two half-days each weekend,

Dr. Frances Harley

drop all forms of physical exercise that require more than 10 minutes, massively reorganize personal and financial responsibilities at home, hope that your housekeeper will pick up what you drop, and pray that you won't have to consult in another hospital more than once a week.

Like most women, I was brought up to try to please others. Thus it is seldom that I say no to a request right off the bat, but in this instance the reason I went home to talk it over with my husband, Raul, was my feeling that I owed Ernie McCoy a great deal.

In April 1984 I was unaware of the many areas Ernie had been involved in, except for those that irritated me because I didn't see their purpose in my fairly narrow view of what I thought the focus of the Department of Pediatrics should be. On the other hand, when I looked around at what my colleagues in pediatric nephrology elsewhere in Canada were doing and recognized the sense of my accomplishment in the areas of cystic fibrosis and pediatric nephrology—due primarily to Ernie's non-directive, non-interfering, but encouraging style—I was personally grateful. Raul was in absolute agreement that I should do anything to make it easier for Ernie to go on his sabbatical. Yes, he and the family would be supportive until the end of June 1985. Even when I realized that Ernie was not only taking a sabbatical but also resigning, I and the family still assumed that someone would be replacing me on the 1st of July 1985. And so I agreed to Ernie's request.

I came on staff in 1972, and until July 1984 I experienced periods of optimism and pessimism in regard to the establishment of a children's hospital in Edmonton. A great deal of work and discussion had gone into trying to convince medical colleagues, as well as politicians, that a children's hospital was needed. Additionally, important planning for the provision and alteration of services for children in individual hospitals had been put on hold pending a positive decision. With the remarks of the Minister of

Health and the Premier of the Province in the latter part of 1983 cancelling all hopes of a children's hospital in our lifetime, the morale of the Department and in pediatrics throughout the City was extremely low. Furthermore, there was general unease in the Department at the University Hospital over the inequity of the space distribution in the new Walter C. Mackenzie Centre and near-panic as to how we were going to squeeze the clinic and faculty members into the space allotted to Pediatrics.

These were the circumstances prevailing at the time I took on the Acting Chairmanship.

What Does an Acting Chairman Do?—Learning on the Job

The state of affairs in pediatrics throughout Edmonton as well as in the Department, plus the fact that the new Chairman in 1985 probably wouldn't be able to get things going for several months after his arrival, was the basis for my thinking about the role of a chairman. Taking all of these circumstances into account, it seemed to me that my definition of 'Acting Chairman' had better be a fairly active one—meaning 'getting on with things', vs the other definition, of 'acting', which might be to pretend or to play the part in such activities as attending functions, nodding around the round table, or simply spreading goodwill throughout the Department.

Very early on in the job I tried to address what the role of a chairman is. Documents put out not long before by the University of Alberta's Vice-President in conjunction with the General Faculties Council and the Association of Academic Staff of the U.of A. were somewhat helpful in outlining the tasks, but I think the phrase that I

had heard uttered by the Associate Dean for Science several years before defined the task for me: that the work of a chairman is to facilitate the work of others. Additionally, of course, there is the role of leadership; and regardless of the leaders I may have admired, I needed to define for myself which style of leadership would be most compatible with my personality and upbringing. Thus I started reading some books I never would have thought of looking at before, and ultimately came upon three analogies.

Some leaders sit at the hub of the wheel, sending and receiving messages via the spokes of the organization while the rim rolls onward. Other leaders act as the lead dog in a team of huskies, pulling or dragging the other members of the organization along. The third analogy is that of the chariot-driver, who stands at the rear of the team screaming words of encouragement or whipping the members who don't appear to be pulling at the traces as hard as he feels they should be. I had hoped to be the hub of the wheel, but I think I was just as often the chariot-driver.

Having decided that I was not going to be a pretend chairman, I set about outlining some goals for myself and for the job at hand. I failed, however, to take into consideration the effects of the new president of the University Hospital, Mr Donald Cramp, and the new Dean of Medicine, Dr Douglas Wilson. Once, when I was in my chariot-driver mode, one of the unfortunate horses snapped back at me: "You're just the latest monkey to reach the top of the tree!" Little did he know that I was not preening in my exalted position at the top of the tree but rather that I was feeling harassed and belittled by being merely the bristle in the two new brooms. Whatever I had on my menu that initially was quite minor had to be squeezed in between the never-ending requests for this and that from the two new supreme monkeys, while still trying to "facilitate the work of others" in the Department.

I resolved early on to try to attend all meetings where I thought the Chairman of the Department should have some influence on the running of the Hospital or the Medical School. This seemed simple enough, but at the beginning I was utterly frustrated that I would be notified of a meeting after it had been held or just advised of the outcome, or I would arrive without the proper documentation, go to the wrong location, or be double-booked. I decided that Ernie had either been some kind of a genius to get to these meetings or perhaps he hadn't gone to very many. The expressions of shock and gratitude when this acting chairman showed up at a meeting, as opposed to the second or third in command, were instructive.

Thus the realization began to dawn on me that the administration of the University Hospital in particular had felt let down by "their Chairman" and had, because of this, been somehow distanced from the medical staff "the users," while at the same time the attending medical staff had felt excluded from input into hospital policy or management. I found it surprising that when chairmen did attend policy meetings they contributed very little; perhaps this was because many of the participants at that time had been in their positions during many years of autocratic, sometimes intimidating, direction from the Hospital. I, on the other hand, was brand new, had too much energy, talked a lot, and started out with a new president, Mr Cramp, who had the most intriguing way of appearing to listen to what you said and then making some incredibly laudatory comment—as, for example:"Dr Harley, what a worthwhile summary," or: "I am so grateful for your thoughtful contribution." Initially I was surprised; my dealings with Mr Cramp's predecessor, Dr Bernie Snell, had been very different. Dr Snell habitually said things like: "Let me rephrase your question," or: "Dr Harley, I don't think you really meant to say that."

Mr Cramp's supply of goodwill and cheeriness to the medical staff was difficult to reconcile with the rumors of heads rolling at

various levels of the Hospital's administration. I recognized that a new administrator in charge of a hospital whose annual budget exceeded 175-million dollars would have the privilege and indeed might need to make some changes in personnel. The first such reorganization took place early after his arrival.

My first (and last) private appointment with Mr Cramp was when he asked for my approval of his new ORGANIZATION CHART. The chart was flashed in front of me for two seconds or less, and not being used to reading organization charts and refusing to wear my new glasses which the tiny print necessitated, I smiled happily, naively marveling that I had been included in making a decision.

Fortunately I did not commit the chart to memory, because it changed periodically, so that by the end of 8 months I was utterly confused. Perhaps he was, also. One of the offshoots of the organization charts and my new title was that I was invited to a number of going-away parties for individuals who had "accepted new positions" elsewhere. The foyer to the Bernie Snell Hall was set up regularly to handle these events and became known as the Departure Lounge.

Accreditation and a Clutch of Committees

One of the first jobs Mr Cramp set about doing was to get us all organized for the next hospital accreditation. We had been reduced from 3- to 2-year accreditation, and he was determined to pull up our socks and put us into the ranks of the 10 other Canadian hospitals whose programs had 3-year accreditation.

This was my first big piece of paperwork. I am sure that when I called Ernie in Washington he thought I was a bit of a loony, because, in the past, accreditation of the Hospital had required of the Chairman only minimal documentation and a short friendly chat with the site visitor. Mr Cramp, however, wanted all the documents reviewed; and he held at least two major hospital meetings at which various department heads illustrated what they were going to say to the inspection team, showing slides and overheads in the Bernie Snell Hall. (No wonder it is called the B.S. Hall!)

The accreditation procedure included demonstrating to the team that you had fulfilled the Standards set out by the Canadian Hospital Accreditation Committee—and a new standard, Quality Assurance, had been added since the last visit. Suddenly, we had to be able to show where we kept the minutes of departmental meetings and various committees (meaning that now we had to start keeping formal minutes); how we checked each year the credentials of pediatricians who admit patients to the Hospital; and how we determined that members of hospital departments attend at least 10 meetings a year. (I'm sure the introduction of seatbelt legislation was easier than our introduction of taking attendance!) The Quality Assurance plan didn't have to be workable until January 1985, but the paperwork had to be finished by September 1984. Tom Ward of the Neonatal Unit was becoming more and more interested in

hospital administration and was very helpful in getting this completed.

As for the accreditation procedure itself, everything went swimmingly for our documentation and I thought we had handled successfully the first challenge thrown to us by the jovial Mr Cramp. But I almost blew it at the end, when, having completed the "friendly chat" with the site visitor, as we were leaving the Department via the Pediatric Clinic he asked: "Now tell me, Dr Harley, what would you do if my child suddenly had a cardiac arrest right here?". As I had never worked in the new Pediatric Clinic (I saw all my nephrology patients in the General Medical Clinic), I did not know where the crash cart was. Having passed the Royal College Examination, however, I have experienced the unexpected, and I was quick to point out that children usually don't have a cardiac arrest like adults do but rather a respiratory arrest, and it is a simple matter to institute mouth-to-mouth respiration while the ever-ready nurse is hauling out the cart from "over there" (I was pointing vaguely at the microscopy room). Fortunately we passed, but I was sweating for a moment thinking that I too might soon be in 'the Departure Lounge'.

Hospital accreditation required an organization chart for the Department of Pediatrics. With Mr Cramp's organization chart in mind, plus ready access to the management library and with a view to quality assurance, I tried hard to get us organized. Even such a simple thing as organizing the mail into color-coded folders was new, as was the addition of chronological in addition to subject-matter filing.

General Faculty Council required that the Chairman have an advisory committee of departmental members. It seemed to me that these advisers should be the chairmen of the Department's working committees and that the Chairman should meet with this Advisory Committee roughly once a month, initially to define the goals of the

Department or to reaffirm the goals of the Chairman and later on to discuss the progress of their implementation. The existing committees and their chairmen were the Residency Training Committee (Dr Paul Taylor) and Education Committee (Dr Bill Taylor) and two new ones: Research Committee (Dr David Schiff), which had a mandate to organize the graduate training program including criteria for selection of graduate students as well as graduate courses) and the Clinical Concerns Committee, initially with me as Chairman and, later, Mario Tedeschini. The Advisory Committee also included Dr John Godel from the Camsell and Dr Neil Finer from the Royal Alexandra Hospital as the academic faculty from those institutions.

This advisory committee ultimately gave me the feeling of where the department was going, overcoming the distraction of the brush fires that flared up almost daily. In this regard I received some useful tips on organizing time and communication with key people in the department from Dr Pierre Beaudry, chairman of the Department of Pediatrics at the Children's Hospital of Eastern Ontario. He gave me two very useful pieces of advice: to keep one's door open, literally, and to have lunch in the cafeteria.

Making sure that meetings were held regularly and achieved something necessitated further trips to the library to study how to run meetings. The best library that I found belonged to Miss Donna Smith, Associate Vice President (Nursing). Facing the crowd on unpopular issues can be intimidating, and there are many examples within the University where I have seen meetings not scheduled, meetings cancelled, or the most important item listed last on the agenda and cut short because of "time constraints" when things got too hot. I decided that, if I wanted to be in the hub of the wheel mode as opposed to the charioteer, I would have to be willing to take the flack; but I hoped the benefits would be a feeling of participation and higher morale of the Department's members—who would have

to live with the decisions. Some of these meetings required a lot of careful planning, because I was never quick enough on my feet for the likes of Tim Woods, Peter Zuberbuhler, or Ehor Gauk. Hospital meetings could even have been described as rowdy, but in the end I thought they were fun and productive.

One of the most tedious, thought-provoking, and difficult times of the year is late November and December, when the performance of every member of a department must be reviewed. Dean Doug Wilson, the second new broom, made it clear earlier in the Fall of 1984 that he would no longer accept a merit increment as being normal. Each one had to be justified, and nothing would be accepted at face value. Never having evaluated anybody's performance in the past I didn't know what the new standard was going to be, and this lack of experience provoked some 'behind the Dean's back' advice from other chairmen.

The first year, I reviewed the annual reports before interviewing each member of the Department to make my own assessment. This assessment then had to be discussed with the Dean before notification of the faculty member as to what the Chairman's recommendation would be. The Dean also receives a copy of the each faculty member's annual report. Our Dean has a prodigious memory: virtually without notes he was able to go through every faculty member's report and assess progress and contribution in terms of grant support and papers published, which of course is what he is most familiar with. I, on the other hand, have a terrible memory for that kind of thing, especially in the area of research.

It became very clear that my focus was quite different from the Dean's and that he was looking for attributes in faculty members, especially the clinical ones, that I had never seriously considered. Thus began a very interesting process for me, that of judging the performance of faculty members whose time is largely devoted to research vs those who carry on a 50/50 clinical/research load vs

those who are almost entirely clinical. The apparently new need to justify faculty members in the Department who concentrate entirely on clinical work was shocking; I came out of my first meeting with the Dean shaken because I had not previously comprehended his vision of a faculty member, nor did I feel that I had represented the Department's members (my team) strongly enough.

I was determined to do better by the final meetings of the Faculty Salaries and Promotions Committee, which meets in February of each year. At that meeting the final determinations of both promotions and merit increases are made, in front of all the other chairmen and a few non-chair Geographic Full Time Academic staff chosen by the Dean. The process was interesting to observe but also intimidating. Each department is discussed in alphabetical order, so that Biochemistry under John Colter, Immunology under Erwin Diener, and Internal Medicine under George Molnar were all discussed before Pediatrics. I hadn't anticipated what a performance this was going to amount to. At my first session with FSCP, promotions were not something that I had to deal with. However, I could see that, like me, many members of the Department were blissfully unaware or had carefully deluded themselves into thinking that clinical excellence would be recognized for promotion. I started to warn various members of the Department about the possibility of roadblocks ahead.

Because of the difficulty I had in translating what appeared to be a new message, I started to consider mechanisms that might be used to describe annually what would be expected of faculty members for the year to come—to be agreed upon by both the Chairman and the faculty member in the nature of a contract. Each divisional head received from me a job description I had plagiarized from George Molnar and General Motors. The late Peter Bowen was enraged, and forever afterwards referred to the outline as "your GM thing." Furthermore, I paid very careful attention to the initial job

description for any new faculty member, to ensure that each item (teaching, research, clinical work, administration), as outlined in the Faculty Agreement, would be fully described and agreed upon in advance.

The annual faculty review is a time when some people get bad news. The giving of bad news to colleagues, news that affects personal pride and self-assessment, is a difficult thing to do emotionally, especially when you care about the people you work with.

Interviewing 40 or more people, combined with trying to convince the Hospital that we needed a Pediatric ICU (left in the old hospital when the new general-systems-failure unit was started up in the Mackenzie Centre), plus the frustration of being unable to recruit a pediatric intensivist, topped off by acerbic rhetoric going between Neonatology and Cardiovascular Surgery all too frequently, was beginning to wear me down. By the winter of 1985 the drudgery of the job was outweighing the undeniably fun aspects of learning new skills. Was I carrying the weight of the whole world on my shoulders? It took two evenings out at movies (The Killing Fields, about personal survival in Vietnam, and secondly El Norte, about escape from central America and survival as a wetback in the USA) to put things into perspective.

Future Roles for the Department

Ernie McCoy had asked Orest Ulan and Wanda Wenman to look at the future roles of the Department of Pediatrics within Edmonton. From their report it was clear that all members of the Department still had a large investment in the idea of a children's hospital as a solution to many problems. I, however, was not prepared to spend another minute thinking about a children's hospital or trying to advocate on its behalf to the provincial government. Instead, I took the report on future roles and selected recommendations I hoped could be handled without the approval of too many other persons or agencies.

The report recommended increasing communication between the pediatric facilities in the various hospitals; thus was Heads of Pediatric Services (HOPS) born. This meeting, usually held about 5.00 p.m. once a month, was made much more entertaining and bearable at the end of the day by the refreshments prepared in Margo Langer's kitchen. Dean Wilson himself attended on at least two occasions and could be seen dipping into the goodies and sipping the fluids. It was a time when concerns could be discussed and the dispelling of rumors could be undertaken; and between Ken Miller and Gordon Selby there were many entertaining moments. Simple things were discussed, such as which hospital would be having empty beds over which month, how hospital administrations were treating common problems, and how we could supply teaching aids to all the teaching programs.

The earlier discussions, however, centered very much on how we were getting on with pediatrics in the City without a children's hospital and what could be done to centralize pediatric facilities within the existing structures. We looked at the advantages and disadvantages of the two-hospital model, the three-hospital model,

and so on. My support for the two-hospital model was not readily accepted by others, which was a disappointment. Goodwill came out of these meetings, however, and over the 2 years we were able to draw upon this co-operative group for other projects. These included City-wide rounds, whose initial intent was to have each hospital invite the pediatric community to its rounds once a year to show off cases of special interest or features of a particular program.

We are creatures of habit, and my car is so used to driving unaided over to the University Hospital that I as well as others arrived late at these rounds simply because I usually wound up at that hospital first by mistake. John Godel's answer to this was to provide the City's best and most generous supply of donuts. Bob Moriarty produced a very interesting speaker from Edmonton's Police Department who spent her summers at Harvard studying the phenomenon of the human acquisition of guilt feelings: the understanding of when it is right to defy authority and what level of intellect it takes to refuse to carry out certain orders, as in the Mai Lai incident in Vietnam, had us engaged in interesting conversations at coffee for days afterwards.

The report by the Future Roles Committee plus a review of the annual faculty reports persuaded me that, as a group, we could benefit from an introductory course on appraising the literature and the basics of how to design clinical research to answer a question. I asked Dr Michael Grace to design this course, and instructed him that he would be giving it to anyone from the Department of Pediatrics, part-time or full-time faculty, and to remember that most of our academic clinical pediatricians had graduated from a Canadian university residency program before 1975: as such, they probably lacked some of the skills needed to appraise literature properly and would have some difficulty passing these skills on to residents. I also wanted Dr Grace to address a frequent comment by clinical staff members: "I would like to do some clinical research, but I don't know how to get it off the ground or whom to contact to proceed with my

idea." The next-commonest comment was heard when laboratory co-operation, statistics know-how, or a source of funding was required: "I can't get anybody to do this for me."

The course designed by Michael Grace was attended by many members of the Department, a few part-time faculty, and from time to time some residents. The outcome of the course, which I called Research Readiness (not to be confused with 'reading readiness') has been very positive, as reflected in our keeping Dr Michael Grace on retainer to the Department as an adviser on preparing grant applications, statistics, research design and fund-raising. Dr Lola Baydala, one of our residents who took the course, subsequently went to England to study epidemiology, and there have been fruitful associations between Dr Grace and other pediatric faculty, including Doctors Pabst, Spady, Harley, Godel and Collins-Nakai. This first step in trying to aid clinicians on the full-time academic staff in directing clinical work to more academic outcomes was simply a first initiative that in retrospect I feel should be continued.

Another area identified by the Future Roles Committee was the need to increase our visibility and stature within the community. My interpretation was that we must come out of the ivory tower and show that the Department was willing to devote time and effort not only to the maintenance of child health but also to promote appreciation of the requirements to achieve this. Margo Langer and I contacted the Alberta Teachers' Association and offered, as a gesture of goodwill and gratitude for the help we get from teachers, to put on a course to help them understand 'Medical Conditions in the Classroom'. The course was poorly attended, possibly because of problems in advertising, but those who did attend never missed and at the end gave rave reviews. The instructors, members of the pediatric community, gave generously of their time, covering a wide range of topics, including Why Kids Are Short, What It Means to Have Cancer, and How Prematurity Contributes to Medical and School Problems in the Classroom.

RECRUITMENT, OR GLITCHES GALORE

Among the varied duties of the Chairman is recruitment. I never anticipated the amount of time, effort, ingenuity, imagination, salesmanship and—most important—energy required to attract, select, entertain, persuade, communicate by telephone, arrange visits, make follow-ups and design contracts. Our department had already recognized the need for a slicker recruiting procedure and most members genuinely wanted to help. But when the time came for the dinner or lunch or attending a seminar, most people were very busy already; it is at such times that this important departmental function of recruitment gets lost. There are no brownie points for that type of co-operation, but there should be. When one considers the number of departments on the University campus that are chronically complaining they cannot hire anyone new, our situation of unfilled positions would appear to be a dream come true; for us, it was a nightmare. We undertook several major areas of recruitment in the 2-year period.

First of all, the chairmanship, although a responsibility of the Dean, from almost every point of view was in fact the work of the Department. We were recruiting at a time when many other faculties in Canada and the USA were recruiting for the same sort of person. Some excellent candidates came to visit our medical school and from these visits we derived important messages. One interesting factor of the recruiting process that changed over the 2-year period of searching was that most candidates bemoaned the absence of a children's hospital. The change in leadership of the provincial government in May 1986, and Getty's campaign promise of a children's hospital in Edmonton to serve Northern Alberta, made us look at potential recruits with the likelihood of

administration of a children's hospital in mind. One of the visitors commented that we had a number of "fine musicians" in the Department but that we "were not playing like an orchestra." Another pointed out that very few of the short bibliographies all departmental members had submitted for the visitor's package noted the person's rank, making the visitor wonder whether rank was meaningless at the U of A.

As a member of the Search & Selection Committee for the new chairman, I organized a meeting of the faculty members to draw up a 'shopping list' of what we hoped to achieve in the selection process. I felt strongly that our department had the potential to develop from one that was largely clinical to become more like those in Montreal and Toronto, where there is a strong emphasis on adding to knowledge of the specialty through both clinical and basic research. With the advent of the Alberta Heritage Fund for Medical Research (AHFMR), even without a children's hospital we were potentially different from such locations as Kingston, London, Sherbrooke, Hamilton and Vancouver.

Despite our wanting to be slick, some incredible glitches occurred during recruitment. For instance, every candidate for the chairmanship was supposed to receive a package of information on faculty members, the University, and the City of Edmonton before coming here. For one candidate, from another continent, an executive secretary decided that the information would arrive too late for the person to read it, because Canada Post would not get it there quickly enough. (Even though Federal Express delivers daily to Moscow and Peking, the idea of using a courier service outside the country never occurred to this lady.) She therefore gave the information package to the Dean to deliver to the candidate at the airport; unfortunately, he forgot to. By the end of his third day here our visitor was displaying a high level of frustration and anger, so I took him out for a milk-shake at the delicatessen on 114th Street and

started to quiz him on what was wrong. I got a blast on how horribly crippled our department appeared; how his entire visit had been a sham, because of the unbusinesslike way it had been conducted. It had? Only then did I find out that the package I had put together so laboriously had never reached him. Profuse apologies made little dent in the visitor's assessment of our competence. The lesson is that sometimes the important details have to be re-checked at every level.

Lots of our visitors had to cool their heels in the Department of Immigration at the International Airport, either missing dinner or delaying it, to the rage of the hostess involved. One, widely renowned, was more than a little humbled by an associate dean who mistakenly assumed he was being recruited for a position in Pathology. On another occasion, my office was associated with an episode of double-booking.

One delightful task I had carried over from my 'previous life' into the first year of the acting chairmanship was the arranging of Pediatric Grand Rounds. Although it is sometimes onerous to persuade people to give rounds, the job does allow you to manipulate the schedule to ensure that your own interests are presented.

A long-held peeve of mine is the way many physicians, residents, and students talk about mothers in terms of good mother/ bad mother, often with extremely disparaging remarks, having had absolutely no experience themselves of the wear and tear of parenting. How could we broaden residents' knowledge of children and childhood? I thought we should try once again to increase our departmental communication with faculties across campus whose stated interest is very close to our own—the child and his family. The first person I asked to speak at Pediatric Grand Rounds was highly theoretical, had no slides (how could anyone come to Pediatric Grand Rounds without audio-visual entertainment?) and

droned on for 55 minutes to the great—and obvious—discontent and disgust of the pediatric audience. The gentleman concerned got the message; he went back to his own faculty across 87th Avenue and our reputation for inhospitable behavior was established.

As a result of this contretemps it was with great difficulty I persuaded a professor of family studies to give a talk to us entitled The Diabetic and His Family, a subject upon which he had spent much time in research. Although we try to arrange the Rounds program well in advance, local speakers are usually cancelled or postponed in the case of unexpected outside visitors, and it so happened that this one had to be asked to postpone his presentation on two occasions. A third date was set up for the Spring; but, 2 weeks before this date, Bridget from the Dean's office notified us that a candidate for the chairmanship would be coming through at that time and we had better get busy making up his schedule, which of course would include Pediatric Grand Rounds. The message came through the day I was going out of town. I instructed one of the secretarial staff to be sure to get hold of the professor in Family Studies to postpone his Rounds presentation once again, and off I went.

The chairman-candidate arrived and I arose in a good mood bright and early on the Thursday morning. As was my custom for all of these visitors, I drove to the Four Seasons Hotel, collected the candidate (Dr Jim Chan, a pediatric nephrologist), did my well-practised—but illegal—U turn in front of the Hotel and proceeded across the 109th Street bridge. There we got stuck in a traffic jam; when that cleared, I drove as fast as I dared to the Mackenzie Centre and parked under the building, and rushed our visitor up the parking-lot ramp, into the Clinical Sciences Building, and up to the second floor. We entered the auditorium through the back door and I showed Dr Chan where to put his slides in the carousel, and then I looked down to the front of the auditorium. There, David Schiff

was looking up at me beseechingly with his arms outst. his right came the voice of the Professor of Family Studies, a.. behind the podium, already with the first slide on, starting to talk about the diabetic and his family, at exactly 8.03 a.m.

As I started down the auditorium stairs with my guest behind me, several ideas crossed my mind, such as: If I trip now, I can create such a diversion that perhaps no rounds at all will take place. If I ask the Professor to step down and not give rounds, our reputation will not only be made worse within the Faculty but may reach the ears of other faculties. If, on the other hand, the chairman-candidate does not give his talk, the Dean will be angry, the Department will be short-changed, our reputation for messing up will become international, and I shall never again be able to face this man at a meeting.

I was forced to decide that I would have to ask the Professor to allow our chairman-candidate to speak at this particular time and hope that the feeble excuse "I think my secretary forgot to phone you" and profuse apology would do. When I got to the office, some time later, I heard that Margo Langer had received an irate telephone call; we decided that the Professor deserved both a handwritten note and a hand-delivered bunch of flowers. But this was obviously not enough, and when I received a copy of the angry letter sent to the Dean of the Professor's faculty and of the one sent to the Dean of Medicine I realized that the floral apology may have been a waste of good departmental funds

Recruiting for the chairmanship and other positions involved some entertaining. Ernie McCoy, who was ably and generously supported by his wife Anne in the area of entertaining, had established an unbeatable reputation and strong traditions both beside the swimming pool and around the dining table. While I could never hope to perform up to Anne's standard, my culture dictates that hospitality requires an invitation into the house. On

the other hand, my husband is from a culture that more often takes a visiting guest out to a restaurant for dinner, and he has a strong aversion to entertaining strangers in his castle. Thus, for the most part the evening entertainment for which I was responsible had to take place either in a restaurant or wait until Raul was out of town.

I worked out the date carefully for when I could safely invite a Robert Wood Johnson Scholar in general pediatrics from Stanford and a doctor who was an Alberta Heritage Scholar from Calgary to come to Edmonton on the same day to talk to us, particularly Don Spady, about research in clinical obesity in childhood. To try to translate this meeting into something of personal value to residents (how does a clinical pediatrician do worthwhile clinical studies?) and to bring them together with faculty, I arranged for a dinner at my house with several residents and some members of the department, together with the two visitors. The dates were right—Raul was going to be out of town. And then, 2 weeks before the event was to take place, the Dean's office called to say that another candidate for the chairmanship would be coming through at that time. I would now be required to entertain the candidate for the chairmanship at the same time as the other two visitors... wonderful!

In these situations I felt I could just make a little more boeuf bourguignon, buy a slightly larger salmon, and add a few more buns to what had become my standard dinner.

When I was younger, my sisters and I had brutally criticized my mother's habit of entertaining at the cottage for numbers varying from 8 to 25, always serving the same meal: cold poached salmon, tomato aspic, salad, buns, and a dessert called sour grapes, all having the valuable attribute of being suitable for preparation hours before use. My menu differed from my mother's only in that the salmon was hot—I used to call our housekeeper to put the foil-wrapped salmon into the 450-degree oven as I was stepping out of the office with the guest of honor. Because on some occasions I had

noticed that not everybody likes salmon, I had added boeuf bourguignon to the menu; and, for the dessert, in addition to sour grapes I had trifle, something that Bill Taylor dives into with great gusto. (When the chairman does not have a wife, some of these details take on added significance, and having been the first female clinical chairman in this medical school, acting or otherwise, I am passing these details on for posterity.).

Two days before the visitation my husband announced that he was not going away and would be gracious enough to join us for dinner at our house.

My contribution to that dinner was largely one of manual labor—passing plates, heating buns, and pouring wine—but Raul was able to make astute observations of this particular candidate. The purpose of such social dinners is, I suppose, to see how a potential member of the Department will get along with the rest of the staff, because there is a lot of room for social interaction that can make or break any more-elevated academic pursuits. Raul found this candidate extremely arrogant, almost insulting, which was alarming if that was the best foot he could put forward. He compared him unfavorably with a non-chairman visitor, Dr Gunner Stickler of the Mayo Clinic, who at another dinner for residents had completely captivated the group with his spontaneity when asked by a resident what he liked about general pediatrics. (My spouse's reaction was ultimately confirmed by "the folks back home.")

The search for a chairman put me in touch with a lot of smart, even brilliant people. Instead of skipping happily along my merry path, I was now forced to look seriously at human character and personality traits; IQ is simply not enough!

Other important areas for recruiting were neonatology, cardiology, pediatric intensive care, genetics, hematology, oncology and a special position for a general pediatrician at the Royal Alexandra Hospital.

Ultimately we were able to recruit Drs Van Aerde and Byrne for the neonatal intensive-care unit, Dr Asad Sheik for the pediatric ICU (this process being heavily dependent upon the efforts of Dr David Schiff and requiring numerous meetings with him and Drs Garner King, Neil Finer, and Pat Penkowski, as well as administration at the University Hospital). Two cardiologists, Dr Yashu Coe and Dr Murray Robertson, were recruited, thanks largely to the untiring efforts of Dr and Mrs Neil Duncan and Dr Ruth Collins-Nakai, and a bonus for cardiology was the beginning of the recruitment of Dr Michael Joffres, a cardiac epidemiologist.

With the resignation of Dr George Eddy after many years as the University-based, half-time general pediatrician at the Royal Alexandra Hospital,we were able to create a full-time pediatric position with guaranteed financial support from the Royal Alex. This was filled by Dr Cecilia Baxter, to the delight of Gordon Selby—who expressed the only positive feelings toward University faculty I had heard in my 2 years! Perhaps easier to recruit (she already knew about the weather) but no less important was Dr Ann Tierney, who joined the neonatology staff at the Royal Alex; and the final addition of Dr Winston Koo to the neonatology roster allowed that group to space out some of the night work and get on with more academic concerns.

Research vs Clinical Care, Teaching and Training

Although our department was known to be doing some research, it was the object of a condescending attitude by basic scientists that was communicated to many other departments within the Medical School and the University Hospital. I was asked repeatedly how much money we had in grant support, and scientists were always eyeing our research space to see whether it was being fully utilized. Life in the Chairman's office was enlivened by the ever-aggressive, acquisitive attitudes of some members within and without the Department, opposing the protectionist posture of the stakeholders.

When one does not have first-hand experience of columns, cell-cultures, fume-hoods, etc., it is difficult to mediate the territorial squabbles that inevitably occur in laboratories, where co-operation is not always at the highest percentile and where suspicion in equating space with power and dignity is rampant. I was fortunate to have the advice of Dr Cam Koch, an internationally renowned basic scientist at the Cross Cancer Institute, who spent time explaining to me how the laboratories could be re-organized at every level to become more productive. We took many tours through the pediatric territories of the Clinical Sciences Building at various times of day, but no major changes were made in the area despite some cautious suggestions on my part.

The critical issue that appeared insoluble was the supervision of basic science laboratories largely by clinicians, who could not supervise efficiently while having to spend so much of their time in other locations. The best-run labs appeared to have maximal on-the-spot supervision by a senior researcher.

My only triumph in this area was my managing to keep Mark Poznansky, associate dean for research, from 'removing' any of our space. I thought it important to hang onto this space for the new Chairman, who presumably would be able to supervise its use better than had been managed to date.

I was surprised at the scant attention the Salary & Promotions Committee paid to the description of faculty members' contributions to the curriculum, teaching, and efforts to obtain training to upgrade teaching skills. The Faculty itself does not pass on the excellence of a residency training program—that is the job of the Royal College, although in a few cases the director of graduate training can refuse to support the application of an individual program.

Our program of training for a pediatric residency had been 'on probation' by the College for many years, and the Pediatric Residency Training Committee under Dr Paul Taylor decided we would either get full approval on the next inspection or resign as a body. Dr Taylor undertook the onerous task of trying to address in turn each of the program's deficiencies.

Through long and laborious negotiations he was able to outline an emergency room experience, through the goodwill of Drs Moriarty, Miller, and Martin at the Edmonton General; all other emergency rooms failed to co-operate. This program had to be revised later, but we had had none before and at least it was acceptable for the 1985 review. We were lucky that the pediatric ICU came into being with the move of the adult ICU into the Mackenzie Centre, so that at least we could appear to be operating as an independent unit. Previously, any pediatricians who rotated through the ICU were directed solely by internists, and this was unacceptable to the Royal College.

A major change was undertaken in the way residents were assigned their work and teaching supervisors. Instead of being located on a single ward, they were attached to a team of physicians

and thus had patients on three or more wards depending upon where the attending physician was admitting patients that month.

It became clear, especially with the reduction in beds in anticipation of the move to the Mackenzie, that there would not be enough general pediatric patients for all the junior residents rotating there. Again with much co-operation from the Royal Alexandra Hospital and the burying of some old memories, and perhaps made more possible by the HOPS meetings but certainly requiring many fruitful trips across the river, we were able to reinstitute the rotation of pediatric residents through the Royal Alex's Department of Pediatrics, at both the R1 and R3 level. This step that not only met with the Royal College's approval but also has proved popular with the residents.

These plus some material changes in the residency program enabled us to change our status to full recognition when the Royal College visited.

The reduced number of beds in the University Hospital underlined once again that most General Pediatrics is currently being taught in hospitals, whereas from a student's point of view it should be taught in pediatricians' offices. Of the four teaching programs for students, only two (at the University and Camsell Hospitals) include regular outpatient experience. The question continues to arise how best to provide access to child outpatients for teaching. I thought one solution might be to utilize the children who come to the University Hospital emergency room at night as an additional Pediatric Clinic, enlisting the services of all the admitting staff as teachers. The Royal Alexandra Hospital's emergency room was receiving by far the majority of these patients.

Again, there were numerous discussion and negotiations with staff of the City's emergency rooms to see where this concept might be introduced; this time agreement was reached, albeit under some duress, that only the University location was feasible. In trying to

fill this teaching role through both full- and part-time faculty I hoped that these extra patients could be followed-up through the practices of the attending staff, at a time when Medi-Centres were competing for the same patients.

It was assumed that pediatricians in the emergency room would be the first to see children who lived in Edmonton, who in the past had not always received such a level of care and certainly not at the speed a pediatrician would be able to deliver it. Thus the night-time clinic got off to a shaky start with much grumbling but a great deal of goodwill. Now, students from the University Hospital and the Royal Alex rotate through five nights each week to increase their experience in ambulatory pediatrics.

Perhaps the most positive aspect of starting this clinic was that almost every one of the Hospital's admitting pediatricians showed up to take a basic life-support course, with a cardiac life-support course specially designed for pediatrics, directed by Ruth Collins-Nakai. Neil Finer showed us how to intubate anesthetized cats and Phil Etches demonstrated various techniques for cannulating placental veins, so now we can all sigh gratefully when our residents respond to a code on the ward, knowing the skill employed in resuscitation.

POSTSCRIPT TO EXPERIENCE

These paragraphs have been in the nature of incidents and memories that were rekindled by my going through about a third of the departmental correspondence. I remember how furious I was when I read the letter the Dean had sent to Vice-President Meekison informing him I would be continuing as Acting Chairman, when he had not even asked me if I would do it. As a result of that oversight, however, I was able to upgrade the position of Chairman's secretary and thus ensure that in future the Chairman will be able to pay an executive secretary who has the organizational skills required for the job.

I have said little about the support required and which I received from my family. Apparently, at the time and in retrospect nobody noticed a big difference in my time commitment or the number of hours I was away from the house. For me, the biggest difference was the greater number of hours required to catch-up on the weekends. Raul was very patient with me, the mail, and my long silences when I was trying to work out problems that I felt were confidential, those things I could not discuss because of the personalities involved (it was always personalities!) who were known to him. It was impossible to bring the office home, except in silence.

A most surprising and helpful feature of the 2 years was the positive support I got from people from whom I least expected help, encouragement, or flattery. For a while I thought it was a well-rehearsed secret scheme on the part of several women throughout the University and in particular the University Hospital. To my surprise, women whom I barely knew came up to me quite regularly to ask how I was getting along and if there was anything they could do to help or to tell me that I was doing a good job. I don't know

Neonatal Intensive Care Unit in the Walter Mackenzie Centre, c. 1990

whether men offer this kind of support to other men, but it is also interesting that many male faculty members approached me or my husband with positive support during this period . I come from the background of a very strict Anglican upbringing, where humility and hard work were stressed; praise or other forms of positive reinforcement were not part of that culture. During this 2 years I certainly learned the difference between genuine and phoney praise for both myself and others. Aside from being grateful for the new administrative task I was challenged with, the opportunity to be part of some interesting group dynamics, I hope I shall remember to recognize more often, and support more positively more often, the contributions of other members of the Department.

The first of July 1986 promised the arrival of Dr Peter Olley as the new Chairman. Relief and vacation were in sight—except that, unbeknown to me, he had arranged with Dean Wilson to delay his

arrival until the 31st of August. The handover I had envisioned didn't take place; instead, I signed out to David Schiff (who had done the bulk of the administration, covering for me for the 2 years) and went on a planned family vacation.

Chapter 5
The Last Five Years: Unfinished Chapter

PETER M. OLLEY, MB, BS, FRCPC, FRCP

In the mid nineteen-eighties, great expectations were raised for the health care of northern Alberta's children, only to be dashed a few years later. The final chapter of this monograph covers the period 1986–91 and ends when the future organization of children's health services for Edmonton and northern Alberta, and contiguous areas, remains uncertain. The 5 years covered also coincides with economic hard times and tremendous social and political pressures on medicine and the health-care system.

Many years of lobbying culminated in an 1985 election campaign promise by the new leader of the Progressive Conservative party, Don Getty. If elected, the future Premier announced, his government intended to build a children's hospital in Edmonton to serve the children of Alberta. Election success followed, and in March 1986 Mr. Getty appointed a Children's Hospital Board under the chairmanship of Mr. Neil Bowker with a mandate to plan and build a hospital.

At the same time, the Faculty of Medicine was seeking a new chairman for the Department of Pediatrics. After 20 years as a pediatric cardiologist and

Dr. Peter Olley

researcher at Toronto's Hospital for Sick Children, I was attracted to the Edmonton position for several reasons. The opportunity for involvement in planning a new hospital and research institute was a major factor, but I was also intrigued by the enthusiasm and commitment of the medical faculty. Under Dean Wilson's leadership there was renewed dedication to building a strong research environment, stemming from the upsurge of enthusiasm when the Alberta Heritage Foundation for Medical Research was established. The opportunity for creativity appeared greater at the University of Alberta than at most other Canadian medical schools.

At that time Pediatrics had several good programs but also some weaknesses. The magnificent Mackenzie Centre provided a home for most subspecialty pediatrics, four other hospitals offered good-quality acute-care programs, and the Glenrose Hospital enjoyed a national reputation as a rehabilitation centre. On the other hand, pediatrics appeared to lack a high profile in the medical school and to receive little attention from University of Alberta students, and the residency program (which had relied heavily on foreign medical graduates) was under provisional approval.

Counterbalancing the opportunities offered in medicine, and particularly pediatrics, was the Toronto vision of Edmonton as the epicentre of an eternal winter, a cultural wilderness isolated from civilization (i.e., Toronto) for at least 10 months of the year. But Dean Wilson (also ex-Toronto) assured me "There is life after Toronto!" and that Canada did not end somewhere east of Hamilton. Convinced, I took up my appointment in mid 1986.

To Be or Not To Be a Children's Hospital

Planning of the Northern Alberta Children's Hospital dominated the first few years of my appointment. When I arrived, optimism was at its highest and an ambitious timetable had been proposed by Mr. Getty by which the new hospital was expected to open in 1992.

From the outset, however, among the public and in sections of the medical profession there was an undercurrent of scepticism about the need for a children's hospital. Several of the City's hospitals had strong community links and were convinced that they must at all costs retain their inpatient services for children. Family practitioners and pediatricians in private practice who had long enjoyed unrestricted access to an almost unlimited number of beds felt threatened. In mid 1986 there were more than 500 pediatric beds in service in Edmonton, far in excess of real needs.

Many argued that the new hospital should be restricted to tertiary care and that the existing hospitals should retain their general pediatric beds. Others believed in more-or-less-complete centralization of inpatient care, with a system of outpatient and outreach programs to ensure community access to appropriate services. Two issues rapidly emerged as central to the early stages of planning: first, the scope of the new hospital, and second its location.

My own view from the beginning was that the concept made sense only if the new hospital were planned as a regional center providing all levels of inpatient care and responsible for the University's academic programs in pediatrics. It also seemed that we had a great opportunity to integrate children's health care in a unique way so that the new hospital not only would look after sick children but also, paradoxically, would devote much of its efforts to keeping children out of hospital and be committed to programs in

health promotion and disease prevention in a way that few hospitals have achieved.

The Children's Hospital Board soon determined in favor of an academic center, defining its role as follows: The Northern Alberta Children's Hospital (NACH) will act as the major hospital in the Edmonton region, providing primary and secondary levels of hospital pediatric care to the community and as the tertiary pediatric referral center for northern Alberta and for some patients from southern Alberta and adjacent provinces.

NACH was intended to enhance and focus public-health education and preventive medicine for children and adolescents, stressing liaison and integration with other health and social services. In education, NACH was intended to become the major teaching center for children's health care in northern Alberta and to provide a wide range of clinical experience for undergraduate and postgraduate students in medicine, nursing, and allied health-care fields. NACH was also expected to be part of the health research complex in Edmonton and to offer a consolidated wealth of clinical research material to investigators conducting research programs that relate to child health.

This ambitious and exciting concept emerged from wide consultation and with the input of many individuals working on over 20 planning committees.

Concurrent with this conceptual plan the Board considered site alternatives. Three possibilities were seriously entertained: adjacent to the Royal Alexandra Hospital, a site on the University campus, close to the University of Alberta Hospitals, and a third, entirely new, location. This question of site location engendered vigorous and at times acrimonious debate. A separate, isolated location was soon discarded, and the debate quickly resolved into one of the Royal Alex versus the University campus. The Board eventually recommended a University location on the west side of 114th Street,

on a site occupied by the Nurses' Residence. This decision was based on the opportunities to share in the many 'hi-tech' facilities available on campus, joint programming in cardiac surgery, oncology, and organ transplantation, and on academic considerations.

While these decisions were being reached the economic situation was changing rapidly. Many years of national and provincial financial irresponsibility finally caught up with Canadians. Health care and education, consuming much of provincial budgets, became the prime targets for reducing costs. Health-care planners rallied behind the banners of Restraint, Regionalization, and Rationalization, promising a vision of tomorrow in which financial credibility would be restored. Reduced hospital budgets resulted in closure of beds and changes in patterns of practice.

Each of the Edmonton hospitals was compelled to balance its budget by closing beds and reducing staff; for example, by 1991 more than 100 beds in the Mackenzie Centre were no longer in operation and a similar number at the Alex had been closed.

In pediatrics, from 1986 to '91 the number of operational beds in the Edmonton area fell from over 500 to 198 and day surgery and outpatient procedures increased significantly. And there was an additional, unanticipated effect of the Children's Hospital project: existing institutions were strongly discouraged from developing new programs in pediatrics, and in some the pediatric services were allowed to deteriorate in the belief they would soon become the responsibility of a new organization.

Much was written and said of the aging of the population, with its implications for health-care costs and priorities. The change in character of inpatients accelerated, with greater effort devoted to the devastating outcome of injury and the chronic results of life-threatening health problems. Psychosocial disorders, including behavioral problems, eating disturbances, suicide, adolescent

sexuality and teenage pregnancy, demanded increased attention, with significant effects on physicians' incomes and teaching programs.

Instant experts filled the news media with their own brands of salvation for the health-care system. The daily paradox, which pitted all of these social pressures for financial restraint against an unprecedented opportunity for miraculous medical achievements, caused great stresses on the system and on individuals. Not surprisingly, the wisdom of investing capital costs of $150-million in a new children's hospital was increasingly questioned.

Alberta's Department of Health maintains tight control of new hospital construction. Each stage of planning is subject to review and approval before the next stage can begin, a system that clearly allows considerable delays. Thus the initial enthusiasm of '86 gradually dissipated as only slow progress was made toward the final goal. By 1989 it was clear that the supporters of a children's hospital had probably 'missed the bus'; economic reality would force reconsideration of the Premier's promise.

Many of us directly involved in clinical care became increasingly frustrated by the lack of any improvement in pediatric services, and more and more it seemed essential to consider alternatives to a free-standing hospital. In April 1991, the Minister of Health announced that she was directing the Northern Alberta Children's Hospital Board to produce a plan for the consolidation of pediatric services into not more than two sites and that the NACH Board would assume financial and operating responsibilities for those services by April 1992.

This directive produced another flurry of interest in child health. It remains uncertain whether it will translate into improved services for the children.

These events, briefly described, and as yet unproductive in the area where it really matters, are nevertheless the backcloth against which all other events of the late '80s occurred.

Changes in Education and Training in Pediatrics

Residents are vital contributors to the success or failure of any academic clinical program. They are the physicians most visible to patients and their families and have the greatest influence on how the quality of care is perceived. Residents are also models for medical students and interns, for many of whom the choice of career is determined by the teaching they receive from a resident they come to admire and respect. Thus, future recruitment of talented persons into pediatrics can be enhanced by a group of enthusiastic, dedicated residents, or adversely affected by residents who are discontented, poorly motivated, and ill informed.

During the early 1980s the University of Alberta's residency program in pediatrics was threatened with loss of accreditation and placed on probation. This was partly a consequence of the organization of pediatrics in Edmonton, lack of a children's hospital making it difficult to provide satisfactory training in emergency pediatrics and leaving considerable gaps in subspecialty expertise. It was also a result of reliance upon a large number of foreign medical graduates, some of whom did not reach Canadian standards. Thus, improving the residency program became a high priority for the Department. A multifaceted strategy was adopted to achieve this objective.

In 1988 David Schiff became full-time director of medical education for Pediatrics. His knowledge and experience, coupled with a sympathetic and understanding approach to both residents and students, has been invaluable. Clinical Teaching Units were introduced, one at the Royal Alex and the other at the University Hospital, that provided a learning environment in which staff,

residents, and students could interact and where residents coul assume increasing responsibility with seniority.

Residents were given greater control over their own education programs, including a weekly academic half-day, and in governance of the Department. The residents' annual conference assumed increased stature, and in 1990 they organized a superb 2-day symposium on Emergency Pediatrics that attracted enormous attention: residents from almost every Canadian program attended, resulting in excellent publicity for the Edmonton school. Clifford Fabian provided outstanding leadership in organizing this conference.

Longer-term initiatives included summer studentships, pediatric electives and selectives, and a departmental philosophy that every faculty member and resident should try to be a model for future pediatricians. To improve the student-interns' 8-week pediatric rotations, over the past 3 years David Schiff and I have lunched with every group of students. Our intentions were twofold. The first was to obtain the students' reactions (positive and negative) to the rotation; this continuous monitoring allowed us to both fine-tune the experience to meet the education objectives and make the rotations as enjoyable as possible. The second aim was to discuss career choices and identify students with an interest in child health. The exercise has been greatly appreciated by the students.

As in many other medical school curricula, pediatrics had not been presented in integrated fashion but provided piece-meal as part of the Phase II systems teaching, but now the Department received approval to introduce an integrated series of problem-based seminars on common pediatric problems as part of Phase II. This was under the leadership of Don Spady, who with his colleagues did a tremendous job of planning to create the course. It was offered for the first time in the fall of 1991, and we are confident that it will both heighten the profile of pediatric medicine in this medical school and

ensure that the students are better equipped for their Phase III clinical rotations.

Changes in medical practice are affecting our teaching programs. With progressive reduction in the number of beds, the increasingly serious condition of inpatients, and the shift to more and more outpatient delivery of care, it is becoming increasingly difficult to provide appropriate training in general pediatrics on the wards. As an alternative we have encouraged the development of a clinic in general pediatrics, and this has become an excellent environment for teaching students; a number of young general pediatricians have joined the teaching staff and brought fresh vigor to the education programs. Throughout the late 1980s, external trends and events had a growing influence on our residency program. Medicolegal issues in the USA stimulated legislation relating to the role of residents, the number of hours they could be on call, and limitations on their responsibility, and here in Canada the Royal College has adopted many of these issues. As part of its accreditation of residency programs, the College now places limits to 'on call' and other service aspects, so that the emphasis is firmly on residency as an educational experience. This creates a challenge for the future, to provide alternative ways that will ensure continuance of adequate care for patients.

Although the residency program has improved immensely during recent years, there are still significant challenges. We need to make subspecialization a more attractive proposition; at present, too few people decide to subspecialize. A research career, also, has little appeal for most physicians, and yet the need for clinical scientists who can link bedside to bench has never been greater. The extraordinary achievements of fundamental investigation must be paralleled by a similar evaluation of this new knowledge at the bedside.

The strength of a department and the programs it is able to sustain ultimately depends on the persons it can recruit. One of the reasons frequently advanced in favor of a children's hospital for Edmonton is that it would assist in attracting more specialists to northern Alberta. Certainly the late '80s were a period of active recruitment in which we were quite successful. It is impossible to say whether that success might have been greater had the hospital existed.

The increasing complexity of pediatrics has stimulated a trend to increasing subspecialization and an ever greater need for persons trained in the effective use of sophisticated technology.

Neonatology has a long tradition of excellence in Edmonton, and the late '80s brought several additional highly talented neonatologists to join the two units. Exciting new technologies, such as extracorporeal membrane oxygenation (ECMO), introduced as a Canadian 'first' in the NICU at the Royal Alex, offered a new hope for many infants with seemingly terminal cardiorespiratory problems. Increased staffing permitted greater emphasis on clinical research in many aspects of the premature newborn, and the ability of neonatologists to rescue infants of very low birth weight and achieve an excellent outcome was one of the triumphs of the late '80s.

The Province's Department of Health designated the University Hospitals as the provincial center for cardiac surgery in children, a decision that implied a significant focus on postoperative care for cardiac patients in the pediatric ICU.

In Hematology–Oncology, the introduction of carefully controlled treatment protocols has improved the prognosis for malignancies in childhood. The Division of Infectious Diseases and the sections of Endocrinology and Gastroenterology have been strengthened, and a pediatric rheumatologist has been appointed—Edmonton's first. The Misericordia Hospital has established a

program of adolescent medicine, and the Glenrose has identified developmental pediatrics as a priority.

Amidst all this recruitment several long-time members retired, although each of them continued to make valuable contributions to the Department's education programs.

Brock Armstrong, although officially retired, continued to be an OSCE examiner, providing the benefit of his wisdom to yet another generation of students. As the official archivist, he has ensured that the Department's history will be familiar to its future faculty. Brock also served the University as a member of the Senate.

To the entire Department's great pleasure, the University recognized Bill Taylor's many innovations in medical education and his leadership in introducing new evaluation concepts to the Faculty, by awarding him its highest recognition for teaching—the Rutherford Prize.

Ernie McCoy, after many contributions to pediatrics and the Faculty of Medicine, began a new career with the Alberta Heritage Foundation for Medical Research and as a Canadian ambassador taking medical aid to the Ukraine.

And the Albertan population is deeply in debt to Peter Bowen, who was a major founder of the provincial Hereditary Diseases Program—one of the very best in Canada. Peter died in 1988, after enduring a long and painful illness with great courage and fortitude.

The Future of Pediatrics in Edmonton

The story of pediatrics at the University of Alberta is one of continuing growth and development. This chapter ends in the early '90s, but it is unfinished: the Department and its hospital programs are poised at the threshold of great change. With so many individuals committed to the health and welfare of children, I am confident the future will see advances in pediatric care, education, and research that are even more exciting.

Young patients in the playroom of the Walter Mackenzie Centre pediatric floor, 1991

CREDITS

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William C. Taylor
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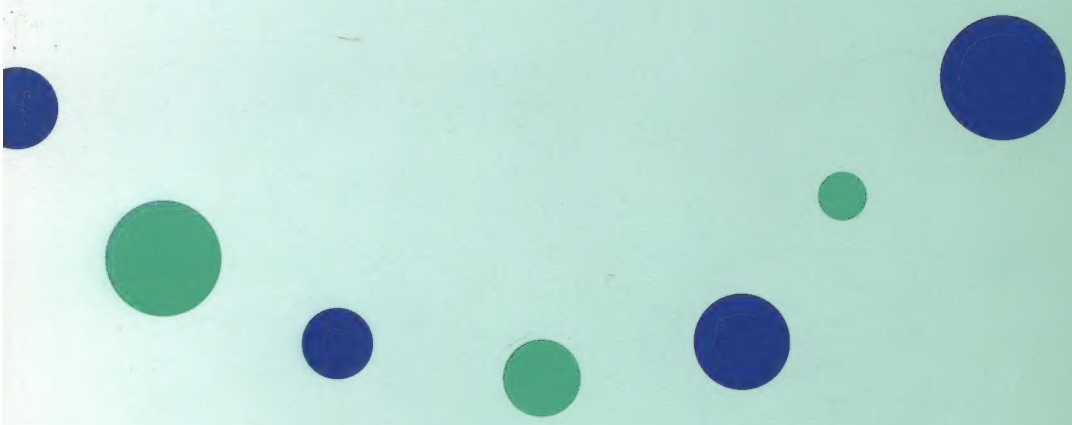

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